Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Danie 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number **Examiner** Hall Center Kandallstaun If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 13, 9. Birthplace (State or Foreign 5. Social Security Number 1924 **Funeral** Months Days 1 □ M 2 🗷 Maryland Dec. Director 219-16-6984 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location fshow the Medical Examiner must be notified at Owings Mills 1 ☐ Yes 2x ☐ No Maryland Baltimore Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 1111 Silentglade Rd. 21117 items 23a by Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status filed within 72 hours after □Yes 2□No 1 Never Married 2 Married ō 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify. **Black** 3X Widowed 4 □ Divorced 'natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager Balto. City Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Savles Ireland ည or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i Cassandra Brown (Daughter) 1111 Silentglade Rd., Owings Mills, MD 21117 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 Department of Important: If it any Injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery [10/10/09] Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 HeV 1/2001

IMV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

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State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		rtificate of L			g. No.	115	33012	)
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death     Month	Day	Year	3. Time of Death	
	/Medic	cal	William Harrison Mechling	<u> </u>			Septembe	1		7:45 AM M	4
	Examin	er	4a. Facility Name (If not institution, give street and number)  Heron Point Nursing		4b. City, Town, or Location of Death  Chestertown			4c. County of Death			
art.	Funeral			(In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth	Kent	9. Birthp	lace (State or Foreign	$\dashv$
	Director		145-03-6493 1X M 2□ F Usual Residence of Decedent	95 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar 7,	Year) 1914	New	Jersey	
	yland how		10a. State 10b. County	10c. City, Town or L	ocation	-			1	0d. Inside City Limits	-
	Ba-fs	cto	MD Kent	Cheste	ertown					1 □Yes 2 □ No	
	in 19	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of V		itry?	
	s 23a	erai	431 Heron Point			620		US			
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene.  Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I to Medical Evaluity I has been any Injury or other traumatic event, I to Medical Evaluity I has been any Injury or other traumatic event, I to Medical Evaluity I has been any Injury or other traumatic event, I to Medical Evaluity I have been any Injury or other traumatic event, I to Medical Evaluity I have been any Injury or other traumatic event, I to Medical Evaluity I have been any I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any Injury or other traumatic event, I to Medical Evaluation I have been any I have bee	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Blac	e - Americ k, White, c : whi		
0500-c	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa e kind of work done d	ation Juring most of work	unk 1	6b. Kind of Bu	siness/Inc	dustry unk	
7	within ene. than "	Completed by	Elementary/Secondary (0-12) College (1-4or 5+	life	DO NOT use retired,	)	9				
0	Hied Hygi Sther ent,	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	laiden Surnam	ie)		-
yiand	Aenta Aenta rked rlc ev	70 B	Edward Anthony Mechling			Edith	Elliott				
Mary	2 shot and Ib is ma auma		19a. Informant's Name/Relationship (Type. Print)		ing Address (Street a			*		Code)	_
≥ . ບັ	Tand Health Sm 27 ther tr		Josephine Mechling/spouse  20a. Method of Disposition		Heron Poi				.620	State State	_
Dalilmor	t. Pages rtment of I rtant: If its rjury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ other (Specify)	,	matory or other place	e) ;		Oc. Location -	-		
Da	permi Depai Impoi any Ir	Į Į	21. Signature of Europe Service Licensee Ronald Service Dire	ctor	2. Name and Addres State Anat Baltimore	tomy Boar MD 212	d 655 W.	Baltin	more	Street	
			23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line	the death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death	
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ď (	Examiner			consequence of):							
	D .::	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of).							-
	and -trans	Examiner	Cause (Disease or injury that initiated events csulfing in death) Last	consequence of):							
00/00,	rincate be executed by physician and as the burial-transit		bue to (or as a	consequence or).							
700	micare ng phy as the	Medical	a					2010			
C. DOX	Finystians: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physiclan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of the pregnant at the pregnant	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		1	te of deliventh	ery Day Year	
L	ned by detac	by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use cont	ribute to t	he cause of death?	
corus,	equires		Hypentension				1 □ Ye	s 2 No	3 ☐ Prot	pably 4 🖺 Unknown	
ביים וו	cate has be	Completed					24a. Was an autopsy perform	/ led?		psy findings available mpletion of cause of	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	certifi rector	Be	25. Was case referred to medical examiner?  Hospital:		Othe	or.	h (Check only one				_
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	rath.	atio	1   Natural 5 □ Pending (Month, Day, 2 □ Accident investigation	Year) Injury	M 1 □	? Yes 2□No					
ZIAID.	io ine nospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	treet, factory, office		28f. Location (Str City or Town,		er or Run	al Route Number,	
	within 24 hours and the Funeral second secon	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner state	examination and/or i	nvestigation, in my o	pinion, death occur	red at the time, da	ate and place,	and due t	o the cause(s)	
Ì	Marit Con To the Con T	ž	29b. Signature and title of certifier	11 1	29c. License	number	29	d. Date signe	d (Month,	Day, Year)	
			29b. Signature and title of certifier  29b. Signature and title of certifier  29c. Cuality  30. Name and address of person who completed cause of de  29c. Arraysat Tr., A.  31. Date filed (Month, Day, Year)  OCT 15 2009  31. Registrat	(U-1)	0-2	3889		10/	110	7	4
~			30. Name and address of person who completed cause of de	atn (Item 23a) (Type	Print)						
			PEHNE ARRABATION. H	1,0, 22	3 1476 (	Freet 11	la tentas	in, W.	1.2	1620	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Swd :45 A M O CTOBER II Albert E, Nazarenus 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death 4b. City. SAINT AGNES HOSPITAL ALTIMORE n/a Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Hours Min. 220-38-7041 7/1/41 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2723 Wegworth Lane 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ➤ Married If Yes, Give Year or Dates 1 ☐Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John C. Nazarenus <u>Catherine E. Easter</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy Nazarenus / Wife Baltimore, Maryland 21230 <u> 2723 Wegworth Lane</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Cemetery 10/15/09 22. Name and Address of Facility Loudon Baltimore, Maryland Loudon 21. Signature of Funeral Service Licen Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryla<u>nd 21229</u> 23a. Part 1. Enter ne disease, or con shock, or his rt failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line. Immediate Cause (Final YESPIRAT ONY TILVRE disease or condition resulting in death) Due to (or as a consequence of): OBSTRUCTIVE PULMONARY DISEASESIX MRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 2 D No 1 ☐ Yes 1 ∐Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

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Examiner burial-trans Physician/Medical i signed by the Completed by page 2 funeral director, Be Medical Certification: To

**Physician** 

Examiner

**Funeral** 

Director

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Director

Funeral

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item 2

Department of Important: If it any Injury or conce.

**Physician** 

/Medical

Examiner

physician

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this

After

within 24 hours

Maryland 21215-0036

Baltimore.

/Medical

25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

D0040012

29d. Date signed (Month, Day, Year) OCTOBER 11.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

CATONSUILLE, MO 405 FREDERICH ROAD

State Registrar 31. Date filed (Month, Day, Year)

POULTON

32. Registrar's Signature

09-07796 Jo

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oshua O. Osunde	State of Maryland /   1-For State Registrar	Certificate of		wentai ny	giene Reg.	No. 200	9 3300		
Physician/				2	2. Date of Death Month D	ay Year	3. Time of Death		
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)	Franklin Square Hospital Center		nb. City, Town, or Lo Rosedale	cation of Death	Baltimore County				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bir 801.35.9178 1 x x 2 F		If Under 1 Year  Months Days	If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace Foreign Country)			gn		
any	Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Locati	on				10d. Inside City Limits		
<b>*</b> ,			011				1 Yes 2 No		
the Maryland a or 28a-f show lifted at once. Director	MD BALT I MORE  10e. Street and Number	MIDDLE RIVER	10f. Zip Code		10g.	Citizen of What Cou	7.77		
the M a or 2 fiffed Dire	9901 DEHAVILLAND WAY APT E.		21220			USA			
death with the Maryland or items 23a or 28a-f shomust be notified at once runeral Director	11. Marital Status 12. Was Decedent E		s Decedent of Hispa es, specify Cuban, h				ican Indian, Black,		
or ite	1 XXvever Married 2 Married Armed Forces? 1 Yes 2 X	X No			vican, etc.)		A		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Comple	OLUBUNMI OSUNCLE	140, 14 %		ADEOLA OS					
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print )		,			er, City or Town, Stat ALE, MD 2122			
and 2 and 2 Health item 2 traun	REGINA HOWARD LCSW C  20a. Method of Disposition	20b. Place of Dispos	ition (Name of ceme			Oc. Location - City o			
Baltimore, permit. Pages 1 a Department of He Important: If ite njury or other tr	1 XX Burial 2 Cremation 3 Removal from State	e crematory or oth MT CARMEL (		10.12	-2009	BALTIMO	RE. MD		
altin mit. P partme portan	4 Donation 5 Other Specify: 21 Son ture of Funeral Service License		lame and Address o						
E P P W		01148 420	6 CRAIN HWY	SW GLEN B	URNIE, MD				
Physician /Medical	23a Part I. Ent 7 the disease, in complications that caused the silure. List only one cause on each line.	he death. Do not enter th	he mode of dying, su	ich as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval Between Onset and		
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Division of Vital Records, P.O. Box 68760, rote Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. In the law special properties that the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Exidedical Certification: To Be Completed by Physician/Medical Exidedical Certification:	JEFEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23a  23c. If yes, outcome 1 Live birth 4 Pregnant at ti 9 Unknown	,27,28a-f,p	erm,E g90	00 2/3/1	0 TT				
760, ficate be g physic s the bur	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome	e of pregnancy		Ectopic pregnar		23d. Date of delive Month	ry Day Year		
x 687 h certifica tending pl use as the ician/A	past 12 months?		etal death 3 ther (Specify)	_Ectopic pregnat	icy	WOTH	Day Tear		
D. Box 6876 the death certificate the death certificate by the attending phy total for use as the Physician/M						<u></u>			
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of Vital Records, ng Physician: The law requirecurent in certificate has been signeral director, page 2 should be not To Be Completed			<u> </u>		autopsy	prior to	completion of cause of		
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Division of spiral or Attending hours after death.  neral Director: Aft willed in by the fund Certification:		residence		þ	pt E M	iddle Rive	Rural Route Number, City Lavilland Way er, MD		
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the edical Certificati	29a. Certifier 1 Certifying Physician: To the best of my								
To the III within 24 Fo the For completed	one) 2 Medical Examiner: On the basis of exam and manner stated.	nination and/or investiga							
_   ≥	29b. Signature and title of certifier	M	29c. License O.C.M			29d. Date signed (M October 8, 2009			
	MM U	(Mary 232)	0.0.10			2000001 0, 200			
	30. Name and address of person who completed cause of de Russell Alexander MD. Assistant Medica		Penn Street, E	Baltimore, MI	21201				
State	31. Date filed (Month, Day, Year) 32. Registrar	's Signature							
Registra	OCT 15 2009 Person	B. park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** October 3, Linda Owens 9:45 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blue Point Nursing & Rehab Ctr Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Jan 28, 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland 6. Sex **Funeral** 1 M 2 T F Yrs. 62 Director 217-46-1159 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner Invest by notiting an once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 W. Belvedere Avenue 21215 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Š 1 ☐ Yes 2 X No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) healthcare receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton A. Arrington Sr Daisy Louise Jackson ం 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Akin Circle Baltimore, MD 21220 Bethany Owens/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 NOther (Specify) in State 21. Signature of Euneral Service Licensee Ronald Say Made Director State Anatomy Board 655 W. Baltimore Street m Baltimore, MD 21201 23a. P m1. Enter the disease of confit cations that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Atherosclerotic **Physician** 1scase ≥ Comos /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown s been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this : After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 TYes 2 TNo 2 Accident investigation Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funaral I 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Contifier Medicai (Check only one)

State Registrar

KAREN W. MEILROTT 31. Date filed (Month, Day, Year) 2009

Messis

30. Name and addr of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

37. Registrar's Signature

25 MAIN ST KETSTERSTOWN, MI) ZIZOS barkel

29c. License number

29d. Date signed (Month, Day, Year)

10/5/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Dorlisa Michelle' Riley 10 2009 6 2:00 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Woodlawn

If I Inder 1 Year | If Under 24 Hrs. Deveraux Ct.#202 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔀 F Months Min. 208569652 32 Director Pennsylvania 11-14-1976 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Modical Experies must be notified at 10d. Inside City Limits Director MD Baltimore XYes 2 □ No Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Deveraux Ct. d 2 should be filed within 72 hours after death v th and Mental Hygiene. ?7 Is marked other than "natural", or items 23s traumatic event, the Modical Examines must #202 21207 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ② No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ Specifyblack 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic Charities Site Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter E. Hodges, III 2 Minnie Denise Riley 19a. Informant's Name/Relationship (Type. Print) mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is 227N.Ingleside Dr.Fayetteville, N <u>M.Denise Riley-Freeman</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Chester, PA 10-15-09 4 ☐ Donation 5 ☐ Other (Specify) Chester Rural Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charisse Woods Fun.Sv.3307Mondawmin Av 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACRHYTHMIA CARDIAC disease or condition resulting in death) DAY I /Medical Due to (or as a consequence of): Examiner DIOPATHIC CARDIOMYUPATHY SYEARS equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify). ned by the a e detached for 1⊠Yes 2 No 9 Unknown けつひか 2009. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown AMHTZA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ WANO 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital of thin 24 hours af the Funeral Di Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 33 407 2009. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEEDAK AVENUE, DUMD ALK SE HTWISE MD 21222 201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kayden Richardson 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 26, 2009 0505 hrs Medical Examiner Richardson Kavden c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Fort Washington Fort Washington Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Days Hours Min. Months Country) DC Aug 7 2009 Director 19 000-00-0000 1 M 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a, State 10b. County any 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Md PG Oxon Hill hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 611 Carson Ave 20745 U.S.A. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: f Yes. Give Yea Divorced 3 Widowed 4 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other transmatic event, the Medical Examiner. à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) 21215-0036 Never Worked 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LaGina D. Richardson Donte Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Mother 611 Carson Ave Oxon Hill Md 20745 2 LaGina D. Richardson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Riverdale Md Riverdale Crematory Donation 5 Other Specify: 22. Name and Address of Facility D.L. McLaughlin Funeral Home 21. Signat e of Funeral Service Licensee 2019 MLK Jr Ave SE Washington DC 20020 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval a. Partil, Enter the dise **Physician** Between Onset and failure. List only one cause on each line Death /Medical Immediate Cause (Final disease Asphyxia jaminer or condition resulting in death) Due to (or as a consequence of): Overlay Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and Pl line a-b, 2/, 28a-f,permE, g896 10/20/09 TT Physician/Medical AMENDED X UNPENDED signed by the attending physician be detached for use as the burial Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live hirth past 12 months Pregnant at time of death 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a, Was an Arter this certificate has been funeral director, page 2 should prior to completion of cause of autopsy death? nerformed? ✓ Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other, examiner? Hospital: 1 Residence 6 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 1 V Yes 28d. Describe how injury occurred 28c, Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death subject asphyxiated Certification: Yes 2X No Natural Pending Fd 8/26/09 Fd 3:00 am X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 611 Carson Ave 2 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 6 3 Suicide house (Specify) To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely cal 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 27, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registra Ana Rubio MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

**OCME** 

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 06, Day 2009 **Physician** Angela Richardson 0920 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13116 Eddington Drive Prince Georges' Upper Marlboro 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month. Day) 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 M 2 XF **5**5 Days Hours Min. 579-72-2536 Washington, DC Director 06/13/1954 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinat must be notified at MDUpper Marlboro X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13116 Eddington Drive 20774 IKA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2x Married ò 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) A.A.S. (1-4or 5+) Daycare Provider Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy F. Barber, Sr. Edna Carter မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest J. Richardson – Husband 13116 Eddington Drive; Upper Marlboro, MD 20774 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of Important: If it any Injury or o 1 Parial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 10/14/2009 Brentwood, Maryland 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final **Physician** myotrophic disease or condition resulting in death) VeaRS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence or attending physician and for use as the burial-transic Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 s 24a. Was an 1 □ Yes 1 ☐ Yes 2 ☐ No 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation neral Director: / 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar

DHMH 17 Rev 1/2001

within 24 hours a

Medical

29a. Certifier

29b. Signature and title of certifier

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To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

>teinberg

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Amend #1. per MD g896 10/15/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State amend 6 per F.H. g898 12/14/71/109at July Death Reg. No. Amihr Nayeem Rucker 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 8:30 october 9 2009 /Medical Facility Name (If not institution, give street and number 4c. County of Death **Examiner** cy medical rer H MO r If Under 24 Hrs. nove  $\mathcal{L}$ If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 <del>N</del> F Months Director 9-28-2009 MARYLAND Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits iral", or items 23a or 28a-f show MD. N/A Director BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4109 GRANITE AVE. 21206 USA Pages 1 and 2 should be filed within 72 hours after death and Mental Hygiene.
The file of the and Mental Hygiene.
The flem 27 is marked other than "natural", or items 23.
The other traumatic event, it is Mentel Economy or the many or other traumatic event, it is Mentel Economy. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0--0-INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ RALIEGH J. RUCKER SHAKERA LATIMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHAKERA LATIMER (MOTHER) 4109 GRANITE AVE. BALTIMORE, MARYLAND 21206 20a. Method of Disposition

1 Burial 2 D Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ot 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) \$ACRED HEART OF JESUS 10-16-2009 DUNDALK, MARYLAND 21. Signature of Funeral Service Livenseg ONATHAN D. HIBNER<sup>2.</sup> Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shark, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Quse (Final disease v ondition resulting death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Year Month 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been si page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica **Director:** After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 9 2009 100061011

State Registrar

31. Date filed (Month, Day, Year)



mpleted cause of death (Item 23a) (Type, Print) edical Center, 301 St Paul Place

1 32 Aegistrar's Signature

Buttimourn 212 02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Carol  $A^{M}$ Surguy October 8:05 13, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Lanie's Place Assisted Living Rosedale If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, August 10, 1935 Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F Maryland 216-34-3957 74 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the findical Experiment to motified at 1 □ Yes 2 🛣 No Baltimore Fort Howard Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9232 Todd Avenue 21052 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates Specify Specify: White ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 1 dealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Automotive 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Hinkelman Margaret Surrett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 I 9232 Todd Avenue, Fort Howard, Maryland 21052 Frederick C. Surguy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition October permit. Pages
Department of
Important: If it
any Injury or c 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 14, 2009 4 ☐ Donation <sup>15</sup> ☐ Other *(Specify)* Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk,Md. 23a. Part1. Enter the disease, complications that caused the death, shock, or heart failure. List only one cause, n each line. Approximate Interval Between Onset and Death ot enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, is a light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of certificate be executed burial-transi Exami and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Physician: The law requires that the death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2 No Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 2 2⊿No 3☐ Probably 4☐ Unknown should 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1√0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

1920 Registrar's Signature Sank

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

141

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28d. Describe how injury occurred ours after death.
neral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Characteristic Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

10d. Inside City Limits

1 ☐ Yes 2 ▼No

21227

Approximate Interval Between Onset and Death

AM

8:55

MD place

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year SIMMS 7:12 AM Maria CLORA E October 12 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSDITA HARBOR n/a Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 8/21/20 6. Sex 7. Age (In vrs. last birthday) Country) Ohio Months Days Hours Min 1 □ M 2 🗙 F 89 302-14-0638 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Kent Ave. 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Nas Deceden Lv Armed Forces? 1 ∐Yes 2 MNo Black, White, etc 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 8 <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Waid Forbes May Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steve Lambert / Grandson 5980 Florey Road Hanover, Maryland Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 10/16/09 Baltimore, Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or conshock, or heart failure. List on dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA 10 days disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 in the past 12 months? 1 ☐ Yes 2 No Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? OBSTRUCTEVE PHIMONARY 1 Tyes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 Mo 1 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

**Physician** /Medical Examiner law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

\$

Completed

Be 2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Marical Examiner in ant be notified at

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending Physician:

To the the

and the burial-tran physician as 1 attending properties for use as the ģ peen cate has by page 2 s certificate

Examiner Physician/Medical þ Completed director, Be this Certification: To funeral After he Funeral Director: Af

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation

1 X Natural 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

RES 000

29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 South HANOVER Street Baltimore

NikitA PozdeYEV 31. Date filed (Month, Day, Year) State

MD 32 Registrar's Signatur

12,2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 October TENENBAUM POLINA Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution street and number) 4b. City, N/A MAI If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-13-1929 5. Social Security Number If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Min. 1 □ M 2 K F Months Days Hours UKRATNE 217-33-7172 80 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3410 ASSOCIATED WAY, #315 USA 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **PESACH** FISHMAN **ESTHER** KAYA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3410 ASSOCIATED WAY, #315, OWINGS MILLS, MD MIKHAIL TENENBAUM/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/2009 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW REISTERSTOWN, MD Signature of Funeral Service Light 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, of complicity ons that caused the death. Do not enter the shock, or heart failure. List only on that ause on each line. Approximate Interval Between nd Death Immediate Cause (Final disease or condition resulting in death) as a consequence of Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 2 23d. Date of delivery 3 Ectopic pregnancy Month Year

Physician /Medical Examiner

Department of Important: If it any Injury or o

**Physician** 

/Medical

Examiner

10a. State

MD

Funeral Director

2

Completed

Be

2

Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

**Funeral** 

Director

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be retified at

Baltimore, Maryland 21215-0036

ant Known as

law requires that the death certificate be executed

and the burial-tra attending pl signed I certificate has page 2 director, this

Box 68760.

P.0.

Division of Vital Records,

Hospital or Attending Physician: The

funeral

within 24 hours after death

To the Funeral Director:
completely filled in by the

IF FEMALE:	
23b. Was decedent pregnant	
in the past 12 months?	
1 ☐ Yes 2 ☐ No	
9 Unknown	

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day,

1 Yes 2 No

3с.	lf	yes,	ou	tcom	e c	of pre	gna	ncy
	1		ve	birth	2	2 🗀 F	etal	dea
	4	□P	rec	nant	at	time	of d	eath

5 Other (specify) 9 Unknown

2 No

23e. Did tobacco use contribute to the cause of death?

Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 100
24a. Was an autopsy performe 1 □ Yes 2

24b. Were autopsy findings available prior to completion of cause of death?

24a. Was an							
autopsy							
performed?							
1 ☐ Yes 2 ☐ No							
(Check only one)							

1 ☐ Yes 2 ☑ No

3 Probably 4 Unknown

							20. I lace of Death (Check Only One)							
Но	spital:	1 Inpatient	2 🗆	ER/Outpatient	3 🗆 [	OOA	Other:	4 🗀 Nursing	Home	5 Residence	6 ☐ Other (Spec	cify)		
	28a.	Date of Injury (Month, Day, Ye	ear)	28b. Time of Injury		28c.	Injury at Work?	0 DN-	28d	. Describe how inj	ury occurred			

27. Manner of Death 1	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factly)	ctory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	ind due to the cause(s) and manner as stated.
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre	
one)	and manner stated	

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

1407018567

29c. License number

29d. Date signed (Month, Day, Year)

Sta	te
D	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 10:37 PM Sonya Turner tober 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 1 F June 16, 1938 Pennsylvania Director 171-30-8613 71 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 273 is merked other than "natural", or Items 23a or 28a-1 show eny hjury or other traumetic event, It. Medical Examines must be notified as 28a-f show 1 ☐Yes 2☐ No MD Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 USA 631 Longwood Court Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: white 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk disabled un k18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Benner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candy Michels/daughter 5662 Newton Road Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify) in state 21. Signalus of Funeral ervice Licenses Renard 6. Wild 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Heteorcha hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? te has age 2 24a. Was an autopsy certific te 1 ☐ Yes 2 ☐ No 1 □ Yes : After this certifical e funeral director, or 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 res 2 No 1 ■ opatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending ie Hospital or Attendii n 24 hours after death. Ie Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Records, P.O. Box 68760, Vita

> State Registrar

DHMH 17 Rev 1/2001

within 24

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

29c. License number D0053568 29d. Date signed (Month, Day, Year)

30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

32 Registrar's

MAPR

Actober 5, 2009 Chesapeako D

OF

Titying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1 - For State Registrar		-	•	artment of F rtificate of		nd Mental Hy	Reg. No	000	33015
	Physici		1. Decedent's Name (First, Middle Calvin Lee						2. Date of Domination Month	Day	2009 Year	3. Time of Death 10:45 P M
>	/Medio Examin		4a. Facility Name (If not institution Southern Maryland	-			4b. City, Town, or <b>Clint</b>			4c. Co	unty of Death	
	Funeral Director		5. Social Security Number 579–68–7947	6. Sex 7. Ag	e (In yrs. last bir 57	thday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bi Min. (Month, D 09/13/1	rth lay, Yea <i>r)</i> <b>952</b>	Cou	place (State or Foreign ntry) Carolina
	or 28a-f show	Director	10e. Street and Number	eG	10c. City, Town		Heights 10f. Zip Code			10g. Citizer	of What Coul	
999	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ininportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Examination and injury or other traumatic event, If a Modical Examination and once.	d by Funeral Director	6801 Holly Berry C	12. Was Decedent Armed Forces? 1 □ Yes 2 ▼		in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □Yes 2 № No Specify:					14. Race - American Indian, Black, White, etc.  Specify: Black	
7.01717	led within 72 hd tygiene. her than "natu nt, the Medical	Completed	(Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or !		(Give life.	dent's Usual Occup kind of work done DO NOT use retired cker Driver	during most (	-	Pr	of Business/In	dustry
ומות	uld be til Mental H irked ott itic even	To Be	17. Father's Name (First, Middle, Calvin Lee Walde						's Name <i>(First, Middl</i> el V. Manley	e, Maiden Su	rname)	
nd 2 choul	ind 2 sho alth and I 27 is ma er trauma		19a. Informant's Name/Relations Mozel V. Walden		- 1		*		r or Rural Route Num <b>Manassas</b> ,			Code)
ָבָּי בְּעַבְּייבָּי בּיבוּ	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition  1  Burial 2 □ Cremation  4 □ Donation 5 □ Other (S	3 ☐ Removal from State	cemete	ry, crer ecti	sition (Name of matory or other place on Cenetery	7 10	Date 0/08/2009	Clint	ion - City or To	
הם ה ה	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee Almay	)	4	2. Name and Addre	ss of Facility	Freeman Fur mple Hills,	eral Se Marylan	rvices d 20748	
	hysician /Medical Examiner		23a. Part Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Metasta	tic Colon	Can		ng, such as o	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	icete be executed physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or injury that initiated events resulting in death) Last	С	a consequence							
.O. DOY 001	septral or Artending Prysician: The law requires mat the death certificate hours after death.  Incredit lirector: After this certificate has been signed by the attending physicilled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1	2 Fetal death		☐ Ectopic pregnand ☐ Other <i>(specify)</i>	ey		230	d. Date of deliv	very Day Year
103,	equires mat en signed b	b	Part II. Other significant conditions respiratory failures						micht			the cause of death?
יו שברי	rine law re cate has be page 2 sho	Completed	lung, h/o pulmona postobstructive p		abetes, le	euco	cytosis,			opsy formed?	24b. Were autoprior to condeath? 1 □ Yes	opsy findings available ompletion of cause of 2 □ No
V 160	ysician: is certific director,	To Be (	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/O	utpatie	nt 3 □ DOA Oth	OF:	of Death <i>(Check only</i>		Other (Spec	ifv)
5 15 15	Attending Pin redeath. Sctor: After the sy the funeral of the fune	Certification: T	27. Manner of Death 1 Natural 5 Pendir 2 Accident invest 3 Suicide 6 Could	28a. Date of Inj (Month, Da igation not be	ury ay, Year) 28b. jury - At home, fa	Time o Injury	f 28c. Inju		28d. Describe	how injury o	ccurred	ral Route Number,
5	ospital or hours afte ineral Dira ly filled in I	al Certi	4 E Homicide	ng Physician: To the besi	of my knowledg	e, deat	h occurred at the ti	ime, date an		ne cause(s) a	nd manner as	stated.

State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland /		tificate of L			g. No:	3. Time of Death	
	Physicia		1. Decedent's Name (First, Middle, Last					Month October C			
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Fort Was	Location of Death		4c. County of Dea	ath	
	Funeral Director		Social Security Number 6. Se		oirthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/13/193	year) 9. Bi C Nord	rthplace (State or Foreign Jountry) The Carolina	
and	w		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Loc	cation				10d. Inside City Limits	
Mary	peniur. Tages I and a Should be med within 72 thous after death min the way at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Evaniner must be notified at once.	tor	MD PG	Fort	. Wast	nington				X Yes 2 No	
with the		al Direc	10e. Street and Number 8390 Indian Head High	way apt B1		10f. Zip Code 20744		11	og. Citizen of What C	country?	
d 21215-0036 filed within 72 hours after death with the Marvland	al", or items 2 Examiner πυε	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🖫 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	-	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes 2 № No Specify:			14. Race - Am Black, Whi Specify: Bla	te, etc.	
U-212	e. an "natura Medical E	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give . life. L	OO NOT use retired	during most of work i)	ing Social Services			
<u> </u>	ed other the event, the	Be	17. Father's Name (First, Middle, Last)  Flace Full-con							ices	
, Maryle and 2 should	alth and Me 27 Is mark er traumation	ပ	19a. Informant's Name/Relationship (7)					ural Route Number, City or Town, State, Zip Code) brt Washington, Maryland 20744			
Pages 1	nent of Hea		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Hemoval from State	æke	sition (Name of natory or other place Crenatory	10/17	/2009 B	20c. Location - City of Peltsville, N		
Balt	Department Important: I any Injury conce.		21. Sign the of Funeral Service Licens	HOOMAN	22	. Name and Addre	ss of Facility Free	man Funera	al Services aryland 207	244	
) / E:	nysician Medical xaminer	Examiner	23a. Part 1. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list or cities, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	e of):  E A de of):	IN	FARCT	ion		Approximate Interval Between Onset and Death	
U. Box 68/60, the death certificate be executed	signed by the attending physician and be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	ath 3E	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of c Month	delivery Day Year	
TOS, P.	n signed b	<u>م</u>	Part II. Other significant conditions of	ontributing to death but not resulting	g in the u	nderlying cause giv	ren in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknow			
LIVISION OF VITAL RECORDS, P.O. BOX To the Hospital or Attending Physician: The law requires that the death cer	within 24 hours after death.  To the Funeral Unector: After this certificate has been s completely filled in by the funeral director, page 2 should	Completed						24a. Was a autops perfor 1 □ Yes	sy prior t med2 death	autopsy findings available o completion of cause of ? es 2 □ No	
VIT.	certifi	Be	25. Was case referred to medical examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpotion	ot all post Oth	er:		ence 6 ☐Other (S	posity)	
Ion of	ath. r: After this ie funeral di	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		o. Time of Injury	f 28c. Inju	4 LI Nursing H		ow injury occurred	респу)	
DIVIS tal or Atte	within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,	
Hospii	e Funer letely fill	Medical (	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, deat and/or in	h occurred at the ti evestigation, in my	ime, date and place opinion, death occu	, and due to the or rred at the time, or	cause(s) and manner date and place, and o	as stated. lue to the cause(s)	
£	withir Comp	Me	29b. Signature and title of certifier	E. Sterm	MO	29c. Licens	c 986	2	29d. Date signed (Max. 10) - 8-		
			30. Name and address of person who d		-			- /	-10 >	+72:-	

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:00 AM M Charles D. M. Weeks September 30, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 840 Maxa Road Harford Aberdeen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 27, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☑ M 2 □ F Hours Min. Year) 30 Pennsylvania 78 053-22-1839 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If ifem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modies Examiner must be refulled at any injury or other traumatic event, the Modies Examiner must be refulled at Director 1 ☐ Yes 2 ☑ No MDHarford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 USA 840 Maxa Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 150-70 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 submariner US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Francis Weeks ၉ Margaret Edith Madenfort 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marijane Weeks/spouse 840 Maxa Road Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signat ... of Funeral Service Ronal of 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death.

Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on -ach line. Approximate Interval Between Onset and Death one cause on ach live. Immediate Cause (Final disease or condition resulting in death) una **Physician** /Medical Lue to (or as a consequence of) Examiner whensom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Due to (or as a consequence of): Box 68760, the attending physician The law requires that the death certificate be Physician/Medical the nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 C Ectopic pregnancy Por in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) □Yes 2□No P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 JUKnown director, page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 □ Yes 2 □ 10 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Desidence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation n 24 hours after death, le Funeral Director Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 0 30. Name and add (Item 23a) (Type, Print) 106

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia		Decedent's Name (First, Middle, Last)	Certificate of De	alli	2. Date of Death Month	Dav	Year	3. Time of Death
/Medic	al	Margaret Louise Woolridge	10 00 To a sales	ation of Dooth	Septembe		2009 y of Death	8:00 AM
Examin	er	4a. Facility Name (If not institution, give street and number)  Manor Care Rossville	4b. City, Town, or Loc				imore	3
Funeral Director		5. Social Security Number 217 −18 −6656   1	day) If Under 1 Year If I	Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, M	ear)	9. Birth Cou	place (State or Foreigntry) sylvania
		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town of Balts						10d. Inside City Limit
a or 28a-	Direct	10e. Street and Number 1000 Franklin Avenue #319	10f. Zip Code 21212		10g	. Citizen of		ntry?
Department of Health and Mental Hygiene. Important: If item 27a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marken Ever, increment the routilised at once.	by Fu	11. Marital Status  1	13. Was Decedent of Hispa If Yes, specify Cuban, W 1 □ Yes 2 X No Si		ecify Yes or No- Rican, etc.)	14. Ra Bla		
ne. han "natur	Completed	(Specify only highest grade completed) ( Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupatior Give kind of work done durin life. DO NOT use retired) waitress	n ng most of worki	ng	b. Kind of I		
her ti	ပိ	10 0		. Mother's Name	(First, Middle, Ma			CI y
ntal hed ot	Be	Joseph Pundzak		Mary Pa	*			
nd Me mark matic	<u>۵</u>		Mailing Address (Street and			City or Tow	n, State. Z	ip Code)
Ith an ?7 is I traul			64 E. Orange				2123	
nent of Hea int: If item 2 iry or other		20a Method of Disposition 20b. Place of [	Disposition (Name of crematory or other place)			·	ı - City or T	own, State
Departri Importa any inju once.		21. Signature of Frheral S. N. elicens e Konale S. M. W. Director	State Anatom Baltimore, M			Balti	nore	Street
nysician Medical kaminer	er	23a. Part 1 Enter the disease, or complications that caused the death. Do no shoot, or heart failure. List only one cause on each line.  Immediate cause (Final disease or or dition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of Due to (or as a c	ASWD	such as cardiac	or respiratory arres	st,		Approximate Interval Between Onset and Death
ig physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of	f):					
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				Date of del Month	ivery Day Year
s been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in	n Part I.		acco use co		the cause of death obably 4 Unkn
ate has	Completed			C. Diago of Dool		ed? No		topsy findings availa completion of cause 2 LNo
s certific lirector,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Othor		h <i>(Check only one</i> ome 5 ☐ Resider		Other (Spe	cify)
after death.  Director; After this certific in by the funeral director,	ation: To	27. Mann of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at Work?		28d. Describe hov			
's after death al Director; of ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)			City or Town,	State)		ural Route Number,
within 24 hours after  To the Funeral Dire  completely filled in b	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	d/or investigation, in my opin	ion, death occu	rred at the time, da	te and plac	ce, and due	to the cause(s)
To t	Σ	29b. Signature and title of certifier  MD	Type, Print)  Type Walk	1727	29	9 2	9 V	h, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)	ann l	vands.	Rom	1.	MD 217

### 09-07649 Esaie A

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Certific	nent of Health and Mental Hy cate of Death	Reg. No.
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) Esaie Amon Beke		2. Date of Death  Month Day Year  4.055 has
iedicai Exammer	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
)	Baltimore Washington Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 24Hrs.	Anne Arundel  8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	578-08-5849 1XM 2F 48	Yrs. Months Days Hours Min.	3/11/1961 Foreign I Vory Country
Aaryland 184 once. ector	c.anara	andria	10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country?
the Marylands or 28a-f sh	10e. Street and Number 61 East Taylor Run Parkway	10f. Zip Code 22314	Ivory Coast
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. Red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If yes 2 No 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12. Was Decedent Ever in U.S.  Armed Forces? 1 Yes 2 X No If yes, Give Year or Dates: 16. College (1-4 or 5+) 4	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify:  Decedent's Usual Occupation (Give kind of w. during most of working life. DO NOT use retirements)	White, etc.    Specify: Black   Specify:
5-0036 iled within 7. Hygiene. I other than the Medical	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
ID 21215-003 should be filed within and Mental Hygiene. 7 is marked other the natic event, the Med To Be Comp	Ogo Beke  19a. Informant's Name/Relationship (Type, Print )	Cecile  9b. Mailing Address (Street and Number or R	Aboueu Aka ural Route Number, City or Town, State, Zip Code)
MD 21 d 2 should th and Me n 27 is ma numatic ev	Hortense A.Sam/Wife	61 Taylor Run Par	kway Alexandria, Va. 22314
Baltimore, M permit. Pages 1 and 2 Department of Health. Important: If item 2 injury or other traum	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donayon 5 Other Specify:	e of Disposition (Name of cemetery, atory or other place) ily Cemetery 11/	Date 20c. Location - City or Town, State 07/2009 Ayaman, Ivory Coa
Balti permit. Departn Importi injury o	21. Sig a of Funeral Service do nsee	19241 Columbia Bl	FUNERAL SERVICE, P.A. vd. Silver Spring, Md20910
Physician /Medical =xaminer	23a. Part I. Enter he isease, or complications that caused the death. Do failure. List inly one cause on each line. <b>Hypertensive</b> Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	not enter the mode of dying, such as cardiac or atherosclerotic card atherosclerotic card	respiratory arrest, shock, or heart iovascular disease Approximate Interval Between Onset and Death
P nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):		
50, te be execut ysician and burial - trai	X UNPENDED X AMENDED 23a, per M #1,23a,27	E g89/ 11/18/09 TT 7, per ME , g897 11/10	)/09 TT
ox 6876 ath certifica attending ph or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnanc 1 Live birth 4 Pregnant at time of death 9 Unknown		23d. Date of delivery
, P.O. B. res that the de signed by the be detached f		ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 ✔ Unknown
Records, The law require ficate has been sig page 2 should b			24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 N
tal Recition: The certificate rector, page	25. Was case referred to medical examiner?	26.Place of Death (Check	
f Vital Physician: ar this certiral director To Be	1 ✓ Yes 2 No		g Home 5 Residence 6 Other:
ion of tending Pl eath. or: After the funera	1 X Natural 5 Pending (Month, Day, Year)	28c. Injury at Work?	28d. Describe how injury occurred
Division opital or Attending oral ster death.  oral Director: After filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
High the Hig	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or	leath occurred at the time, date and place, and r investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. t the time, date and place, and due to the cause(s)
H-fend West of Tarit	29b Signature and title of certifier 200 and manner stated.	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 2, 2009
	30. Name and address of person who completed cause of death (Item 23a Victor Weedn MD JD Assistant Medical Examiner		21201
State Registrar	31. Date filed (Month, Day Year) 22. Registrar's Sign ture	pares	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 24,2009 **Physician** BOYD 11:00 AM MITCHELL EARL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CLINTON NURSING & REHAB. CLINTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 09 | 20 | 1955 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months 54 578-74-8138 ALABAMA Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be retified at WASHINGTON DC 1⊈Yes 2□No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3632 BROTHERS PLACE S.E. #103 20032 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mential Hygiene.
Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: BLACK ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) PRINTER GAYLORD HOTEL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM L. BOYD ပ္ MARY FRANCES WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2020 BROOKS DRIVE #725 FORESTVILLE, MARYLAND 20747 LYNN BOYD/ SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 3 Removal from State 1
☐ Buria! 2 ☐ Cremation 10-01-2009 RESURRECTION CLINTON, MARYLAND 4 ☐ Donation ☐ Other (Specify) 3005 12th STREET N.E. TWASHINGTON, BCAL HOME LLC Approximate Interval Between Onset and Death 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immeriate Cause (Final **Physician** dise e or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐No 1 ☐Yes 2 K No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 09-28-2009 MD8172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 OLD BRANCH AVENUE #101 CLINTON, MARYLAND 20735 KHOSROW DAVACHI 32. Registrar's Signature 31. Date filed (Month, Day, Year, State 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Eugenia Brown Sept 10:57 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Country) 1919 Mary Land If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) Days Hours 1 D M 2 Director 90 220 12 2654 Sept Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Prince George's Upper Marlboro 10g, Citizen of What Country? 10e. Street and Number Funeral 20772 United States 4520 Lordslanding Road Apt 106 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 277 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Supervisor - Food <u> Army Exchange Service</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Chew Mamie Bruce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James F. Brown (Son) 20 Covenant Court, Hampton, Virginia 23666 20a. Method of Disposition

1 🖰 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Oct 3, 2 at 009 Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Signatur of Funeral Le 🕡 e Licensee Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cevemo vascular accident Acute Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal Sec. ☐ Pregnant at time of death ☐ Unknown in the past 12 months?

1 Yes 2 No Day Month 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by osteo povosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MONGEVY page 2 s this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 1 Yes 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medical funeral director, Be examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifle 29c. License number 0042049

Registrar
DHMH 17 Rev 7/2009

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pegistrar's Signature

pper Marchoro - mb -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Marylant		tificate of		ı wemanı	Reg. No.	0115	33021
		1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
Physic /Medi			lanchette				Octol	Der 4,	2008	2/30 M
Exami	ner	4a. Facility Name (If not institution, give str	1 -	#	4b. City, Town, o	(	eath	4c. Col	unty of Death	
<i>pt</i>		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast hirthday)	If Under 1 Year	If Under 24 H	Irs. 8. Date of B		9. Birthpla	ace (State or Foreign
Funeral Director		232-66-4256 Usual Residence of Decedent	v <b>2</b> √2 F 6	Vrc	Months Days	Hours M	in. (Month, L	Day, Year) 10,194	Count	Virginia
aryland show	_	10a. State 10b. County		, Town or Loc					10	d. Inside City Limits 1 □ Yes 2 ☑ No
the M	ect	Maryland Prince  10e. Street and Number	George s	Laure	10f. Zip Code			10g Citizen	of What Count	
with i	Ö	501 Main Street,	Apt. 222		20707	7		U.S.		.,,
be filed within 72 hours after death with the Maryland tell Hygiene.  Identify than "natural", or items 23a or 28a-f show event, the Modeal Exemples.	by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 ऒ No If Yes, Give		Vas Decedent of I f Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		Race - America Black, White, et	tc.
2 hours a satural", o		Widowed 4 ☐ Divorced  15. Decedent's Educa	Year or Dates:	16a. Deced	l □Yes 2□Xlo	pation	varkina		ecify: Whit of Business/Ind	
within 7 within 7 jiene.	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire — Employ		vorking	Grap	hic Ar	ts Studio
al Hyg	Be C	17. Father's Name (First, Middle, Last)					Name (First, Middi		name)	
should be and Mental smarked o	2	Harold Robinson		T		_	e Horne			
Mall y 2 sho th and the mad 7 is me traums		19a. Informant's Name/Relationship (Type Robert M. Blanch		1	-		mbell, I			
Te, Ind I yie s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	20b. P		sition (Name of natory or other pla		Date	-T	ion - City or Tov	
Dallillor permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 【XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Ard	ent C	rematio	on Serv			er,Mar	-
Dermi Depar Impor any ir		21. Signature of Funeral Service Licenses	ullo	6	Name and Addr	ford R	Marzull oad,Bal	lo Fun Ltimor	eral C e,Mary	Chapel,P.A land21214
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complex shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line.  Due to (or as a consequ	ero7						Approximate Interval Between Onset and Death
trificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to its insculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequ							
To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregna 1  Live birth 2 Fetal 4  Pregnant at time of d 9  Unknown	death 3	Ectopic pregnan Other (specify)	су		23d	I, Date of delive Month	ry Day Year
ires that signed by I be deta	by	Part II. Other significant conditions cont	ributing to death but not resu	llting in the u	nderlying cause g	ven in Part I.		d tobacco use		e cause of death?
necords  le law requires has been sign ge 2 should be	Completed						24a. Wa	as an 2	24b. Were autop	osy findings available npletion of cause of
The it. The icate hings							pe 1 □ Yes	rformed? 2.☐No	death?	2 □ No
vital sician; T s certifical irector, pa	o Be	25. Was case referred to medical examinera	espital: 1 ☐ Inpatient 2 ☐	EB/Outnation	st 2□ DOA   Ot	hor:	Death (Check only	_	Othor (Cassif	d
ding Phy	HE.	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju		<del></del>	e how injury or		'/
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify					(Street and Nown, State)	lumber or Rura	l Route Number,
Hospit 24 hours Funera etely fille	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date and p opinion, death o	lace, and due to to occurred at the time	he cause(s) ar le, date and pla	nd manner as si ace, and due to	tated. the cause(s)
To the within To the сощр!	Me	29b. Signature and title of certifier			1	ise number			signed (Month, I	
		30. Name and address of person who com	pleted cause of death (Item	23a) (Type.	Print)	2535	27	Octo	60 C	, 2005 and
		Spluster Sil	vester 30	7/4	spita	l Dr	ve C	Lever	(c M.	anyland
St	ate	31. Date filed (MCTax 15,72009	2. Registrar's Signa	are	12.0					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 27, **Physician** 2009 Theresa Cahill 8:50 al /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brooke Grove Nursing Home Sandy Spring If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign
Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕱 F 579-44-4009 Director 77 1932 Washington, DC Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Directo 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 6 items 23a 14514 Homecrest Road, Apt. L29 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examinational once. 20906 TISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 15 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Judicial Clerk Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Egan Veronica Daniels ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael F. Cahill/Son P.O. Box 174, Rehoboth Beach, DE 19971 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 5, Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Acense Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Day Year 5 Other (specify) detached f 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Urinary Tract Infection, Chronic Obstructive Pulmonary Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Disease, Dementia, Lung Mass, Anxiety, 24b. Were autopsy findings available prior to completion of cause of death? autopsy Gastroesophageal Reflux Disease 1 ☐Yes 2 No 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) t ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending fter death. I irector Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital of within 24 hours of To the Funeral D 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

31. Date filed (Month, Day, Year) SEP 30 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

one)

29b. Signature and title of certifier



29c. License number

D57630

29d. Date signed (Month, Day, Year)

September 28, 2009

onald Buck Thom		Crabtree State of	Maryland / De	epartment d Ce <i>rtificate</i> d	of Health and	d Mental Hy		200	9 3302
	Re	gistrar Decedent's Name (First, Middle,Last)					Reg. N 2. Date of Death		3. Time of Death
Physician/ ledical Examine				C Inomas	OTABLICE	ļ	Month Da September 30	), 2009 <sup>Year</sup>	1426 hrs
icaidai Zxaiiiiio		Roland Thomas CRAI  a. Facility Name (if not institution, give st	reet and number)		4b. City, Town, or	Location of Death		4c. County of Death	
		1324 Potomac Avenue, Apar			Hagerstown			Washington	
Funeral	5.	Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Yea		8. Date of Birth (M	MM/DD/YYYY) 9. Birt Cou	hplace (State or Foreign untry)
Director		218-34-2775 1XM	2F	72 Y	rs. Months Day	s Hours Min.	Nov. 19	1936 Ma	ryland
	U	sual Residence of Decedent							10d. Inside City Limits
, any	1	0a. State 10b. County	10c.	City, Town or Loc	cation				1 X Yes 2 No
Maryland 28a-f show 1 at once,	5	Maryland Washingt	on	Hager	stown		1100	Citizen of What Cour	ntry?
the Maryland a or 28a-f sh lifted at once	3 7	0e. Street and Number			10f. Zip Code		Tog.	Citizen of What Cook	,
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1215 Id be file Mental H narked c		Lee Arthur Crabtro	e			Mary El	len Gill	i um er, City or Town, State	7:- 0-42
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygene. n 27 smarked other than tumatic event, the Medica	2	9a. Informant's Name/Relationship (Typ	e, Print )						
e, MD 21 I and 2 should Health and Me Fitem 27 is ma	L	Steven Crabtree -	Son	106	01 August position (Name of co	t Court,	Williams	ort Mary	r Tand 21795 r Town, State
re, s 1 an f Hea ff iten	- 1	20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from State		r other place)	errictery,	Date	,	
Pages		4 Donation 5 Other Specify:		Hagerst	own Crema			0	n, Maryland
Baltimore, ME permit. Pages 1 and 2 & Department of Health at Important: If item 2/1 ainjury or other traum:	1	21. Signature of Funeral Service Licens	e n	` / /	2. Name and Addre		Minnich !	Funeral Ho	ome
<b>@</b> 80 = .i.	$\perp$	23d. Part I. Enter the disease, or compli	11/4mm	dooth Do not ont	+15 E. Wi	1son Blvd	Hagers	town, Mary s, shock, or heart	Approximate Interval
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Orc aw re nas be 2 sho	E e						autops	ned? death	?
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Division of Vital Records, P.O. Box 6876C tal or Attending Physician: The law requires that the death certificate is after death.  "al Director: After this certificate has been signed by the attending physelled in by the funeral director, page 2 should be detached for use as the beautiful to the funeral director, page 2 should be detached for use as the beautiful to the funeral director.	Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpa		Other Nur		Residence 6 🗸 Ot	her: Scene
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Division of Vital   To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not determine	ne	, y ramon o name	, , ,		or Town, St	tate)	
Cospits hours noera unera		4 Homicide	To the best of my	knowledge, death	occurred at the time	e, date and place, a	ind due to the caus	e(s) and manner as s	stated.
To the Hos within 24 h To the Fur completely	lical	(Check only 1 Certifying Physics one) 2 Medical Examine	:On the basis of exami	ination and/or inve	estigation, in my opin	nion, death occurre	d at the time, date	and place, and due to	the cause(s)
To To corr	Medical	29b, Signature and title of certifier	and manner stated.		29c. Lic	ense number		29d. Date signed (	Month, Day, Year)
		100			0.	C.M.E.		October 1, 20	09
	3	30. None and address of person who	complete a use of de	ath (Item 23a)					
5H1+1		Laron Locke MD. Assis	tant Medical Exa	miner 111 F	Penn Street, Ba	altimore, MD 2	1201		
	ate	31 Date filed (Month, Day, Year)	32. Registrar	s Signature	1				
Regist		11. 98.23	008	the A	Jakel.				
DHMH 17 Rev 1/20	001	OCME		ORIG	SINAL				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	or waryland		rtificate of De			g. No. 2 0 0 S	33025
	Physici	an	1. Decedent's Name (First, Middle, Last)  Clarence L.	-	C1a:	rk		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street an	d number)	OIG.	4b. City. Town, or Lo		Septembe	er 24,2009	
,	Examin	er	Kline Hospice House	a namber)			iry		Frederic	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year If		8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
и	Director		234-01-8868 <sup>1</sup> ₩ <sup>2</sup> □	F 93	Yrs.	Months Days		JAN. 30,		ine
	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Maryl -f sho ied a	tor	Maryland Frederick	Fi	reder	ick				1XTYes 2 □ No
	n the	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	th witi 23a o 1st be	Funeral Director	406 Culler Ave.			21701			United St	ates
	r dea tems er mi	nue	Arme	Decedent Ever in U.S. of Forces?	13.	Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
21215-0036	I within 72 hours after death with the Maryland jeene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	If Yes	es 2 □ No , Give or Dates:			Specify:		Specify: W	hite
5	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade comple	ted)	6a. Dece (Give	dent's Usual Occupatio kind of work done duri DO NOT use retired)	on ing most of workin	g 1	6b. Kind of Busines	s/Industry
121	filed within Hygiene.  Hygiene.  Ither than "	dmo	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)		Manager			Lumber Su	nnly Co.
	al Hygie other	Be Co	17. Father's Name (First, Middle, Last)	1. !	ратез		3. Mother's Name			ppij co.
Maryland	و ق ج ج	To B	Charles E.	Clark			Viola	D.	Edmunds	
ary			19a. Informant's Name/Relationship (Type. Print,		19b. Mailir	ng Address (Street and	d Number or Rura	Route Number,	City or Town, State	Zip Code)
Σ,	is 1 and 2 of Health a item 27 Is		Craig Clark			Meadowbro				1702
Baltimore,	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal f	20b. Plac cem	e of Dispo etery, crei	sition (Name of natory or other place)	Da	ate 2	0c. Location - City o	r Town, State
Ë	t. Paç rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)		ffer	Crematory	09/25	/2009   F	rederick,	Maryland
Bal	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	terson	$\begin{vmatrix} 2i \\ 1 \end{vmatrix}$	2. Name and Address of 621 Opossur	o <sup>r Facility</sup> Stau mtown Pi	ıffer Fu ke / Fre	neral Hom ederick, N	e ID 21702
			23a. Part 1. Enter the disease, or complications t shock, or heart failure. List only one cause	on each line					st,	Approximate Interval Between
No.	Physician	Ì	immediate Cause (Final disease or condition	Obstre	utt	ve hep	athis			Onset and Death
4	/Medical Examiner		resulting in death)	Obstue e to (or as a consequen acters in	ce of):	Total 1	1 1	o		
		Į.	Sequentially list conditions  if any leading to immediate	e to (or as a consequen	ce ot):	mar 10	reeding			
100	uted	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(			U			
oʻ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	e to (or as a consequen	ce of):					
68760,	ate be hysici he bu	Medical	d						· · · · · · · · · · · · · · · · · · ·	
39	ertifica ling pl	Med	IF FEMALE:	11.3.33	-	277-172	0	5.2	754	
Вох	eath cer attendin for use	Physician//	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnancy Live birth 2  Fetal de	ath 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
o.	that the de	ysic		Pregnant at time of deat Jnknown	n 5L	Other (specify)				
٠ <u>.</u>	that ned by deta		Part II. Other significant conditions contributing	to death but not resultin	g in the u	nderlying cause given i	in Part i.	23e. Did tob	acco use contribute	to the cause of death?
rds	quires an sign uld be	ed by	aute Dement	70	·			1 □ Ye	s 2 ∰No 3 □	Probably 4 ☐ Unknown
ပ္ပ	aw rei as bee 2 shoi	plet						24a. Was an	24b. Were	autopsy findings available
Division of Vital Records,	ding Physician: The law requires Ar. Ar. Include this certificate has been sign funeral director, page 2 should be	Completed						autopsy perform 1 🗆 Yes 2	ed?/ death	o completion of cause of ? es 2 □No
/ita	Physician; r this certific ral director, p	Be (	25. Was case referred to medical examiner?			T	6. Place of Death	(Check only one	:)	
of o	Physi this c al dire	္	1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER			4 Li Nursing Hon			pecify) Itospice
L C	ding l	ioi	1 Natural 5 Pending	Date of Injury 28 Month, Day, Year)	lb. Time o Injury	Work?	t s 2 □No	8d. Describe ho	w injury occurred	
İSİ	Attending r death. ector: Afte by the fune	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e.	Place of Injury - At home	, farm, str	The second secon		8f. Location (Str	eet and Number or	Rural Route Number,
ᅙ	al or / s after I Dire	Certification:	4 Homicide determined	Place of Injury - At home building, etc. (Specify)		,		City or Town		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: T 2 Medical Examiner: On and	o the best of my knowle the basis of examination manner stated.	edge, deat n and/or in	h occurred at the time, evestigation, in my opin	, date and place, a nion, death occurre	and due to the ca	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within To th∉ compl	Me	29b. Signature and title of certifier	n h		29c. License n	umber	29	d. Date signed (Mo	nth, Day, Year)
			· A	1110.		MDD 54	4636		9/25/0	9
	Ex!		30. Name and address of person who completed							
	)		Sayed Haque / 700 M			Frederick,	, Marylai	nd 21701		
	Sta Registr		31. Date filed (Month, Day, Year) <b>SEP</b> 2 9 2009	32. Registrar's Signature	1. 4	backel				

DHMH 17 Rev 1/2001

For State Dir Baltimore, Maryland 21215-0036

Reg.	Nó.

Md.

Gaithersburg,

20879

99025

			Registrar				Cei	rtificate of	Death			Reg. No.	. U U D	00040
Ī	Physic		1. Decedent's Name (F FLORENCE	First, Middle, Last		AS					2. Date of De Month	Day	Year 5 2009	3. Time of Death 3:00 P
	/Medi		4a. Facility Name (If no	nt institution give	street and number)			4b. City, Town, o	r Location o		Эерсени		County of Deat	
?	Examir	ner	Victoria'											
_		-	5. Social Security Numb			je (In yrs. last	hirthdou	Gaithe			8. Date of Birl		lontgome	
	Funeral Director		228-26-70 Usual Residence of De	007 10	M 2 <b>X</b> F 7. Aç	83	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	Co	hplace (State or Foreign untry) rginia
	and w		T	Ob. County		10c. City, To	own or Lo	cation						10d. Inside City Limits
	arylis sho dat	F	Md.	Montgo	merv			nsville						1 ☐ Yes 2 No
	e M Ba-f tiffie	Sc					ay cor	15 V IIIC						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.	al Director	10e. Street and Numbe 8401 Gosh		Drive			10f. Zip Code	2088	2		-	en of What Co nited S	
	ms (	ner	11. Marital Status		12. Was Decedent	Ever in U.S.	13.	Was Decedent of H	lispanic Orig	gin? (Spec	ify Yes or No	- 1	4. Race - Ame	
)	after or ite nine	Funeral	1 Never Married	2 Married	Armed Forces? 1 ☐ Yes 2 💢 If Yes, Give	No		ir Yes, specity Cub 1 □ Yes 2 🛣 No		n, Pueπo F	ilcan, etc.)		Black, White	e, etc.
	ral", c	<u>5</u>	3X Widowed 4□	Divorced	Year or Dates:			TLI Yes 2004, NO	Specify:				Specify: V	∛hite
)	72 hc natu lical	Completed	15.	5. Decedent's Edu only highest grad	ication	1	6a. Deced	dent's Usual Occup	ation	t of workin		16b. Kir	nd of Business/	Industry
	Med "I	롈	Elementary/Seconda		College (1-4or	5+)	life. L	kind of work done DO NOT use retire	d)	t Of WORKIN	g			
	d wit	6	12	., (,	Ö	/	Sec	cretary				A	gricult	ture
	othe ent,	Be C	17. Father's Name (Firs	st, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden S	Surname)	
3	d be enta ked c ev	To B	Thomas	H. Cr	aig				$\mathbf{L}$	ula	W.	Fish	er	
	mari mati	F	19a. Informant's Name	e/Relationship /Ti	/ne Print)	1	19h Mailir	ng Address (Street	and Numbe	er or Rural	Route Numb	er City or	Town State 2	Zin Coda)
	d 2 s th ar 7 is trau		G. R. Clu					l Goshen						, ,
5	l an Heal	1.5	20a. Method of Disposit			20h Place		sition (Name of			ate		cation - City or	
	ges If ite		·		Removal from State	ceme	etery, crer	natory or other pla	, ,				•	
	men ant:		4 ☐Donation 5 ☐	☐ Other (Specify)	)	Metr	opol:	itan Crem	l.	9/27/	709	AL	exandr:	ia, Virginia
	port port by In		21. Signature of Funer	al Service Licens	_	/	22	Name and Address Muriel F.	ss of Facility Bar	ber I	uneral	Hom	ne	
			muu	el H	Barke	N		P. O. F	80x 50	38, 1	Laytons	svill	e, Md.	20882
			23a. Part1. Enter the of shock, or heart fa	disease, or compailure. List only o	lications that cause ne cause on each li	d the death. D	o not ent	er the mode of dyin	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition			epsis								Onset and Death 2 Weeks
•	/Medical		resulting in death)		a	a consequen	ce of):							
	Examiner						,	r Disease	7					9 Years
		ē	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Disease or inju-	ions, ediate	D.	a consequen		z zzodase						
	nsit nsit	i	Cause (Disease or inju	iry										
	and and al-tra	Examiner	that initiated events resulting in death) Last		c Due to (or as	a consequent	ce of):							
	be e ician buria				,	,	,							
)	cate ohys the	dic			d									
	certificate be executed nding physician and use as the burial-transit	n/Medical	IF FEMALE:		20 1/									
			23b. Was decedent pre in the past 12 more	egnani	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	y			2	<ol><li>3d. Date of del Month</li></ol>	ivery Day Year
	e de	sici	I□Yes 2□N		4□Pregnant a 9□Unknown	t time of death	n 5[	Other (specify) _					WOTH	Day Tear
	at the by t	Physicia	9 🗆 Unknown											
	The law requires that the death ate has been signed by the atte page 2 should be detached for	by F	Part II. Other significal	nt conditions co	ntributing to death b	out not resulting	g in the ur	nderlying cause giv	en in Part I.		23e. Did t	obacco us	se contribute to	the cause of death?
	quire in siç uld b	pe	Anemia								10	Yes 2	] No 3 ☐ Pr	obably 4 Unknown
1	w re	Completed									24a. Was	an	24b. Were au	rtopsy findings available
	he la has ge 2						_				auto		prior to death?	completion of cause of
1	r: TI icate r, pa										1□ Yes	2X No	1 ☐ Yes	2□ No
	Attending Physician: r death. ector: After this certifice by the funeral director, a	Be	25. Was case referred examiner?	l-r	Hoopital:			Tout			(Check only o			
	hys this o	유	1 ☐ Yes 2 🔀 No			ent 2 ER/			4 LI Nu					cify)Group Home
'	ng P	ü	27. Manner of Death  1 Natural 5	5 Pending	28a. Date of Inju (Month, Da		<li>b. Time of Injury</li>	f 28c. Injui Woi	y at k?	2	8d. Describe I	now injury	occurred	
	ath. arth. or; A	atic	2 ☐ Accident	investigation		6.74			Yes 2□I	No				
	er de	iji	3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e. Place of inj	ury - At home c. (Specify)	, farm, str	eet, factory, office		2	8f. Location (8 City or Tox	Street and	Number or Ru	ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:			Daniering, et	o. (opoony)					Ony Or 101	m, Giale)		
:	nour:		29a. Certifier	Certifying Phy	sician: To the best	of my knowled	dge, deatl	h occurred at the ti	me, date an	nd place, a	nd due to the	cause(s)	and manner as	stated.
:	e Hc e Fu letely	Medical	(Check only 2	☐ Medical Exam	iner: On the basis of and manner st	of examination ated.	and/or in	vestigation, in my	opinion, dea	th occurre	ed at the time,	date and	place, and due	e to the cause(s)
1	o the o	Me	29 Signature and title	e of certifier				29c. Licens	e number			29d. Date	e signed (Mont	h, Day, Year)
1	<b>⊢</b> ≶ <b>⊢</b> ő		10	D Y	1,0	2 i	1	ם	19294				- '	26, 2009
		1	THE A	100/	www		VI)					1		•

State Registrar

Division or Vital Records, P.O. Box 68760,

911 Russell Avenue,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Melnick, M.D.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER **Physician** 8:00 a M 2009 HARRIETT IDA CLOUGH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil 20 2nd Ave. Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 31 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F Maryland 87 1922 215-14-0429 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be redified at 1 XYes 2 □ No Director MD Cecil Cecilton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 131 N. Bohemia Ave. 21913 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1 ☐Yes 2 X If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Beauty Shop Hair Dresser 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Padley Howard Benson ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traum 20 2nd Ave. Elkton, MD. Betty Krischbaum (daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 10/9/09 Cecilton, MD. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign three of Funeral Service Launsee 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 M00510 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or contition resulting in death) Physician ne a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a d be detached f □Yes 2 No P.O. g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 1 ☐ Yes 2 No 1 □Yes 2 NO 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Daughter Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After t 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00035779 October 7. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruce Obenshain,

DHMH 17 Rev 1/2001

Dr

State Registrar S. Bohemia Ave. Cecilton, MD. 21913

M.D.

32. Regi trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 5:15 AM **Physician** 2009 DETOBER Stephanie Smith Colburn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Long Green Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Sept. 24, 1945 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 1 F Vermont Director 64 008-32-9576 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County ns 23a or 28a-f shov 1 ☐ Yes 2 XNo **Funeral Director** Reisterstown Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 U.S.A. 212 Glyndon Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status the Medical Exercitors 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Private Investigator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iona Keneson Morris Barrett ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Merrimack Road, Amherst, New Hampshire 03031 Bethany Hayward /Daughter item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 10-7-09 20a. Method of Disposition Pages 1 jo permit. Pages
Department of
Important: if it
any injury or or 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cremation Services 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 21. Signature of Funeral Service Licensee michael P. margull 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or commentations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final YUARS REATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 Suicide within 24 hours after de

To the Funeral Directo
completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Maryland 21215-0036

3altimore,

Box 68760,

P.0.

Records.

Vital

Division of

**ORIGINAL** 

9005

2. Registrar's Signature.

29c. License number

D31136 OCTOBER 7, 2009

KILBRIDERD, BALTIMORE, MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lillian M. Cramer 10:10 PM 2009 October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Washington **Examiner** Town, or Location of Death 110 Southern Oak Drive Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-72-6480 1 🗆 M 2 🖾 F Months Days Hours 82 November 21, 1926 Mary land Director Usual Residence of Decedent 28a-f show 10b. Counts 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director Maryland Hagerstown Washington 1 Yes 2 X No 10f. Zip Code 21740 5 10e. Street and Number 10g, Citizen of What Country? 23a Funeral 110 Southern Oak Drive United States within 72 hours after death "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harrison John Dixon Mary Mae Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9208 Garnes Road, Mercersburg, Pennsylvania 17236 Lisa Shoemaker / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 9, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 2009 Frederick, Maryland 21. Signature of Fune? 22. Name and Address of Facility Keeney & Basiord P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Ovarian Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Tinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Petal death Ectonic pregnancy for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Other (specify) Dav Year as been signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Jas page performe certificate | 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital Other: 2X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending after death. 1 Yes 2 No Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Edward James Davis September 30, 2009 11:18PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital of Cecil County Ceci1 E1kton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 222-10-6915 84 July 22, 1925 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Modical Examment and injury or other traumatic event, Item Modical Examment and injury or other traumatic event. 1 ☐ Yes 2 ☑ No Director Maryland Ceci1 North East 10g. Citizen of What Country? 10e, Street and Number United States 21901 195 North Main Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 ☐ No 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XX If Yes, Give Year or Dates: WWII Specify. White þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public Schools 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Esther Clark Edward James Davis ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1725 Ironside Road, Newark, Delaware Earnest N. Davis/Son 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 1, 1 ☐ Burial 2 remation 3 ☐ Removal from State Mayerdale Crematory Newark, Delaware 4 ☐ Donation ☐ Other (Specify) 2009 | Newalk, B 22. Name and Address of Facility 21. Signatur of Put 127 South Main Street, North East, Maryland 21901 Approximate Interval Between Onset and Death 23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) erebrovascular Days Due to (or as a consequence of): Examiner Physician/Medical ģ Completed

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Be

Certification: To

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, it any 1 course there underlying cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)  9 ☐ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed?  1 \[ \superset \text{Ves} \ 2 \]  1 \[ \superset \text{Ves} \ 2 \]  24b. Were autopsy findings available prior to completion of cause of death?  1 \[ \superset \text{Ves} \ 2 \]  1 \[ \superset \text{Ves} \ 2 \]  24b. Were autopsy findings available prior to completion of cause of death?  1 \[ \superset \text{Ves} \ 2 \]  24b. Were autopsy findings available prior to completion of cause of death?  1 \[ \superset \text{Ves} \ 2 \]  24b. Were autopsy findings available prior to completion of cause of death?  24c. Were autopsy findings available prior to completion of cause of death?  24c. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical	26. Place of Death (	Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Injury  M  28c. Injury at Work?  1 □ Yes 2 □ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	if, Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)

Medical State Registrar

29b. Signature and tile of certifier

29d. Date signed (Month, Day, Year)

10.1.2009.

Joo23322 10.1.

High St Elhan MD21921. 30. Name and address of person S. Sacho

OCT 0 2 2009

		State of Maryland / Department of Health and M  1- State Registrar Certificate of Death	_	giene ,	009	33031
Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day	Year 2009	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Company of the Company o	ty Date of Bird	4c. Cou Balt	nty of Death	place (State or Foreign
Director		037-22-2620 1 M 2 F 74 Yrs. Months Days Hours Min. Usual Residence of Decedent	July 9	y, Year)	Coui	e Island
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the ZT Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other traumatic event and injury or other event and injury or other event and injury or other event and injury or other event and injury or other event and injury or other event and injury or other event and injury or other event and injury or other event and injury or other event and	Director	10a. State 10b. County 10c. City, Town or Location  Maryland Washington Hagerstown		40-03		0d. Inside City Limits 1 ☐ Yes 2 1 No
ems 23a or 3	eral Dir	10e. Street and Number         10f. Zip Code           19420 Jeswood Drive         21740           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent of Hispanic Origin? (Sp. 13. Was Decedent of Hispanic Origin?)		10g. Citizen		
036 urs after d	by Fun	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Year or Dates:	Rican, etc.)	E	Black, White,	
1215-0036 ithin 72 hours a ne. "natural", o	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king		f Business/In	·
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Maryla Maryla nd 2 should lith and Me 27 is mark	<b>ل</b>	Norman Drake  Ethel  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rule)  Portry, Loop Drake  104.20 Journal Drains III	ral Route Numbe			,
Baltimore, services 1 an Department of Heal Important: If item 2 any injury or other once.		Betty Jean Drake - Wife 19420 Jeswood Drive, F  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Rose Hill Cemetery 10/9	Date	20c. Location	on - City or To	own, State
Baltii Baltii permit. 1 Departm Importal any inju		Rose Hill democely (10)	innich F	uneral	Home	<u>Maryland</u> 21740
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Division of Vital Records, P.O. Box f To the Hospital or Attending Physician: The law requires that the death certif within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending investigation  3 ☐ Suicide 6 ☐ Could not be determined  28e. Place of Injury (Month, Day, Year)  28b. Time of Injury Mork?  1 ☐ Yes 2 ☐ No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (SCity or Tou	Street and Nu		al Route Number,
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To the virthin comp	Ĭ	29b. Signature and title of certifier  29c. License number  D066810		29d. Date sig	R 4,	Day, Year) 2009
64-15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sharon Weintrub Mp Sina; Hospital of	Balt	inon	د	
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DHMH 17 Rev 1/2001

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			Registrar  1. Decedent's Name (First, Middle, Las	stì		sitincate of	Deaiii	2. Date of De	Reg. No.		3. Time of Death
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20	<u> </u>		5. Social Security Number 6. S	ex 7 Age	(In yrs. last birthda	v) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth		ace (State or Foreign
	Funeral Director			☐ M 2 <b>X</b> F	83 Yrs.	Months Days	Hours Min.	(Month, Da 10–07–	ay, Year)	Coun	Virginia
			Usual Residence of Decedent					10 07	1723	WCDL	virginia
	yland Now		10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits
	Mar	to	Maryland Washingt	on	Williams	sport.					1 ☐ Yes 2 XNo
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5	of H fite		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, c	position (Name of rematory or other pla	C8)	Date	20c. Loc	ation - City or To	wn, State
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Baltimor	permit. Pages Department of I Importent: If ite eny injury or of once.		21. Signature or Funeral Service Lice	rsee	0.0	22. Name and Addre	ess of Facility Ineral Hom	e P.A.	425	S. Conoc	ocheague S
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			23a. P. T. Enter the disease, or com- nock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not one.	enter the mode of dy	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
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5	i Dir	Certification:	4 🗀 Homicide	building, etc	. (Spacity)			Only Of TO	, Diale)		
	e Hospitel 24 hours a e Funerel l letely filled			nysician: To the best of							
	e Hos	dical	(Check only 2 Medical Examone)	miner: On the basis of and manner sta		investigation, in my	opinion, death occui	rea at the time	, date and	piace, and due to	une cause(s)

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State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

OCT 0 6 2009

Katem Smith CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kate M. Smith CRNP 333 Mill St. Hagerstown, MD 21740

DHMH 17 Rev 1/2001

R128088

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day Month Year 2009 **Physician** September 25, 2:47 P.M Dolores Marie Douglas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 784 Ouince Orchard Boulevard - T2 Gaithersburg Montgomery 8. Date of Birth (Month, Day, Ye. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday <sup>Year)</sup>1949 5. Social Security Number 6 Sex **Funeral** Min. Months Days Hours 1 ☐ M 2 🕏 F Sept. Maryland 60 214-52-5876 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it of Wealch Examiner must be a cultical 1 □Yes 2 □ No Director Maryland Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 784 Ouince Orchard Boulevard - T2 20878 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐Yes 2 💢 No Specify. Specify: White þ 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Documentation Specialist Pharmacuticals 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked ony injury or other traumatic ev Beniamin Palmer Robeson Stella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906–6134 19a. Informant's Name/Relationship (Type. Print) 15150 Callohan Court, Silver Spring, Maryland Barbara D. Manilla - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Dpnation 5 ☐ Other (Specify) Metropolitan Crematorium 9/29/09 Alexandria, Virginia 21. Signature of Fineral Service License 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dose 5 **Physician** C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 2 No 1 ☐Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ this in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. To the l within 2. To the I 29d. Date signed (Month, Day, Year) Signature and title of of rtifier 29c. License number

State Registrar

Baltimore.

P.O.

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

		-	_ State	State of Maryland	-	ertment of F			ene.	) (1) (1)
	Physicia	an	Registrar     Decedent's Name (First, Middle, Last)     Geraldine Helen	Fellers				2. Date of Death Month Septembe		3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give str Brooke Grove Nurs	reet and number)		Sand	Location of Death		4c. County of Deat	tgomery
	Funeral Director		5. Social Security Number  151-18-0713  Usual Residence of Decedent	7. Age (In yrs. I	84 <sup>Yrs.</sup>	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 30	Year) Co	hplace (State or Foreign untry) ew Jersey
	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, its Medical Evaninar must be notified at once.	Funeral Director	10a. State 10b. County  Maryland Montgome  10e. Street and Number	ry	y, Town or Lo	nsington 10f. Zip Code		10	g, Citizen of What Co	10d. Inside City Limits 1 □Yes 2 🖾 No untry?
020	urs after death v al", or items 23a exeminer must	by	9700 Carriage Roa  11. Marital Status  1  Never Married  Married 3  Widowed 4 Divorced	Q. Was Decedent Ever in U.S Armed Forces? 1		20895 Was Decedent of H f Yes, specify Cuba 1 □ Yes 2□ No	Ilspanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
0-01212	d within 72 hor giene. Ir than "natur. Ir Medic II	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed)  College (1-4or 5+) 2	(Give life. l	dent's Usual Occup kind of work done DO NOT use retired stered Nu	during most of work d)	ing	6b. Kind of Business/ Heal	Industry th Care
yldila	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Edmund Hmieleski				Lilli	e (First, Middle, M. an Swiatk	cowski	
c, Mai	1 and 2 sho Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Type Eileen F. Sarsfiel	d/Daughter	9700	Carriage	Road, K	ensingtor	n, MD 2089	5
	permit. Pages 1 Department of I Important: If Ite any injury or of		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Century	moval from State Ga	te of :	sition (Name of natory or other place Heaven Ce Name and Addre rancis J 00 Unive	emetery ess of Facility Collins	ept. 30 2009 s Funeral	Silver Spr Home Inc.	ing, Maryland
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line.  Pneumonia  Due to (or as a consequence)	h. Do not ent					Approximate Interval Between Onset and Death 2 days
	Physician: The law requires that the death certificate be executed that the second that the certificate has been signed by the attending physician and that director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unwerlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Parkinson's  Due to (or as a consequence of the con	uence of):	5 <b>e</b>				3 years
O. DOX 0	he death certific r the attending p ched for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of c	al death 3 [	☐ Ectopic pregnand ☐ Other (specify) _	гу		23d. Date of de Month	livery Day Year
ecords, r.	requires that t een signed by nould be detac	þ	Part II. Other significant conditions cont Cerebrovascular Dise					ion 1□Ye	s 2 <sup>34</sup> ⊡ No 3 □ P	o the cause of death? robably 4 ☐ Unknown
vital nec	an: The law I rtificate has b tor, page 2 sh	e Completed	25. Was case referred to medical				26. Place of Dea	24a. Was an autopsy perform 1 □Yes 2	y prior to ned? death? IX No 1 ☐ Ye	utopsy findings available completion of cause of
DIVISION OF V	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 □ Inpatient 2 □ 28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 28c. Inju Wor M 1 [	ry at	28d. Describe hor	nce 6 Other (Spewinjury occurred	
A C	Hospital or A 24 hours after Funeral Direc stely filled in b)	edical Certif	4 ☐ Homicide determined  29a. Certifier ★ Certifying Physic	28e. Place of Injury - At he building, etc. (Specifician: To the best of my knoter: On the basis of examina and manner stated.	owledge, deat	th occurred at the t	ime, date and place	City or Town	ause(s) and manner	as stated.
<b>)</b>	To the To the To the Comple	Med	29b. Signature and title of certifier	with manner stated.		29c. Licen:	se number D23958	29	9d. Date signed (Mon Septembe:	th, Day, Year) r 29, 2009
	٦		30. Name and address of person who cor Burt I. Feldman, I				Blvd., \$	Silver Sp	ring, MD	20906

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 3 0 2009

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 25,  $A^{M}$ Alfred Fowler 2009 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Olney, Maryland Marylanu
If Under 24 Hrs.
Hours Min.
April 7, Montgomery Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days 85 240-18-7974 1924 South Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location eu onner than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 1 X Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1221 M Street, NW #119 20005 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 □Yes 2 ▼ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Black 3 Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Service Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Maggie Flower 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau Monica R. Hill - Daughter 18703 Crosstimber San Antonio, Texas 78258 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Lee's Crematory Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 30, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, D.C. 20019 Approximate Interval Between Onset and Death 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s1-ck, or heart failure. List only one cause in each line. Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical D e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 ponahema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown 24b. Were autopsy findings available prior to completion of cause of death? omia 24a. Was an autopsy performed 1 □Yes 2 NO 2 ☐ No eral Birector: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated

the Hospital 24 hours a completely To the within 2

or Attending Physician: The law requires that the death certificate be executed

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Division of Vital Records,

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certificate

1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene.
em 27 is marked other than "natural", or items 23a or

3altimore, Maryland 21215-0036

State Registrar 29b. Signature and title of ceptifier

OCT 0 1 2009

nuanso

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Monta

32. Registrar

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

09-07741 Robert Friedel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 33935

Program of Program of			For State		Certific	ate of	Death				eg. No	C U	3. Time of Death
As peculiar Name   Service   Physician/ dical Examine	1. r	Decedent's Name (First, Midd	ROBER					d	Date of Dea Month October 5	, 2009		1824 hrs	
Social School specified for the state of processed in the state of pro		4a			number)	4					Dorch	nester	
The state of the s		5.											Country)
VINCENT D. FRIEDEL / BROTHER  1 Bundl 2 / Johnston 5   Other Specify  20 - Bused of Disposition   Name of carellary    1 Bundl 2 / Johnston 5   Other Specify  22 - Name and Address of Facility  MID SHORE CREMATION CENTER 2272, HUDSON RD., CAMBRIDGE, MD  23 - Part I: Either the disease, or complications that caused the death. Do not emirrh the mode of dying such as cardiac or respiralory streat, shock, or heart  23 - Part I: Either the disease, or complications that caused the death. Do not emirrh the mode of dying such as cardiac or respiralory streat, shock, or heart  24 - Donation 5   Other Specify  25 - Part I: Either the disease, or complications that caused the death. Do not emirrh the mode of dying such as cardiac or respiralory streat, shock, or heart  26 - Part I: Either the disease, or complications that caused the death. Do not emirrh the mode of dying such as cardiac or respiralory streat, shock, or heart  26 - Part I: Either the disease, or complications that caused the death. Do not emirrh the mode of dying such as cardiac or respiralory streat, shock, or heart  27 - Part I: Either the disease, or complications that caused the death. Do not emirrh the mode of dying such as cardiac or respiralory streat, shock, or heart  28 - Part I: Either the disease, or complications of chronic alcoholism  29 - Part I: Either the disease, or complications that caused the death. Do not emirrh the mode of dying such as cardiac or respiralory streat, shock, or heart  28 - Part I: Either the disease, or complications of chronic alcoholism  29 - Part I: Either the disease, or complications of chronic alcoholism  29 - Part I: Either the disease, or complications of chronic alcoholism  29 - Part I: Either the disease, or complications of chronic alcoholism  29 - Part I: Either the disease, or complications of chronic alcoholism  29 - Part I: Either the disease, or complications of chronic alcoholism  29 - Part I: Either the disease, or complications of chronic alcoholism  29 - Part I: Either the disease, or complication	-0036  I within 72 hours after death with the Maryland gigene.  When than "natural", or items 23a or 28a-f show any ther than "natural", or items 23a or 28a-f show any e Medical Examiner must be notified at once.	Luileiai Diectoi	As State 10b. County MD DC  De. Street and Number 113 I  I. Marital Status Never Married 2 1  I. Widowed 4 D  15. Decedent's Education (Sp. Elementary/Secondary (0-12)	DRCHESTER  BELVEDERE  12. Was D Armed 1  Yes ivorced If Yes, Give Nor Dates ecify only highest g	E AVE. lecedent Ever in U.S. Forces? 2 X No (rear	13. Wa	s Decedent of les, specify Cub Yes 2 X 1 13 Usual Occupost of working i	2161: Hispanic Orig an, Mexican, No specify: Dation (Give life, DO NOT	in? ( Speci Puerto Rid kind of wor use retired	ify Yes or N can, etc.) k done	0- 14. I Spe	Race - Am White, etc cify: of Busines	USA  merican Indian, Black,  WHITE  mess/Industry
230 Year   12   15   15   16   16   16   16   16   16	should be file and Mental H is marked of atic event, the	g   2	9a. Informant's Name/Relation	nship (Type, Print)	1	9b. <b>Ma</b> ilin			nber or Ru	ral Route N	umber, City o	r Town, St	tate, Zip Code)
23	Saltimore, MI smit. Pages I and 2. epartment of Health a nportant: If item 27 jury or other traum		0a. Method of Disposition  Burial 2 Cremati  Donation 5 Other	on 3 Remova	20b. Place crem	atory or ot ORE CR 22. I	sition (Name of ther place) REMATION ( Name and Addr	cemetery, CENTER ess of Facilit	10/6	Date 5/2009	20c. Loca	CAMB	RIDGE, MD
The color of the	Physician /Medical raminer		failure. List only one cau mmediate Cause (Final disea or condition resulting in death Sequentially list conditions, f any, leading to immediate any, leading to immediate (Disease or injury that initiated	b. Due to (or a b.	ations of chronic a as a consequence of): as a consequence of):			ng, such as c	ardiac or r	espiratory a	arrest, shock,	or heart	Approximate Inter Between Onset a Death
296. Signature and title of certifier  O.C.M.E.  October 6, 2009  30. Name and address of person who completed cause of death (item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	nat the death certificate be executed nat the death certificate be executed ed by the attending physician and enached for use as the build - transit	Physician/Medical	UNPENDED  F FEMALE: 3b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9	d. AMENDI	ED  es, outcome of pregnan ve birth regnant at time of death nknown	2 F	Other (Specify)			23e. Di	d tobacco us	onth e contribu	Day Year
296. Signature and title of certifier  O.C.M.E.  October 6, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ecords, P	subleted t								at pe	utopsy erformed?	prid dea	or to completion of cause ath?
29b. Signature and title of certifier  O.C.M.E.  October 6, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Vital Re hysician: The this certifical director, pa	a	examiner? 1 ✓ Yes 2 No	Hospital: 1			nt 3 DOA	Other <sub>4</sub>	Nursin	g Home 5			
29b. Signature and title of certifier  O.C.M.E.  October 6, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Division of ital or Attending Purs after death. ral Director: After Illed in by the funers		1 V Natural 5 F 2 Accident 8 Suicide 6 C 4 Homicide	rending nvestigation 28e. Could not be etermined (Specific Rendered)	Place of Injury - At homecify)	e, farm, st	reet, factory, of	Yes 2	No etc.	28f. Location Tow	on (Street and vn, State)	Number	or Rural Route Number,
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To the Hosp within 24 hos To the Fune completely fi	Zeal. Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and manner stated.  Zeal. Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and manner stated.  Zeal. Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and manner stated.  Zeal. Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and manner stated.						occurred a	due to the	29d. D	ate signed	(Month, Day, Year)	
				Assistant Medi	cal Examiner 1	11 Penr	Street, Ba	Itimore, M	D 2120	1			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician <u>10:1</u>6 P <sup>™</sup> Dasani Ternee Carter Green July 30 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🖾 F Months Days July 8, 2009 Director Maryland None Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City, Town or Location te 1X Yes 2 No d other than "natural", or Items 23a or 28a-f s event, Its Medical Evanities and the motified Director Clarksburg Maryland | Montgomery the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 22601 Frederick Road 20871 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify 2 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If Item 27 Is marked any injury or other traumatic evonce. Green ဂ္ Terry A1an Tara Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tara Carter/Mother 22601 Frederick Road; Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/9/09 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Furieral Sinice Licensee 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fairure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate wuse (Fin widisease or condition resulting in death) **Physician** <sub>a.</sub> Apnea 3 hours /Medical Due to (or as a consequence of): Examiner Trisomy 13 22 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or impury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2XNo cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 □Yes 2 K No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this hours after death.

neral Director: After this y filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 15 MM 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Goldberg tlan K. MP 1500 Forest Glen Road; Silver Spring, MD 20910

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT

09

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 25 2009 9:15 Anthony Angelo Grande

Months

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

Frederick

Hours

Min

3. Time of Death

Birthplace (State or Foreign Country)
\_\_\_\_\_\_

20882

Month

1 ☐ Yes

Day

2 No

26/2009

21701

Year

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2 No

Pennsylvania

4c. County of Death

1922

8. Date of Birth (Month, Day, Oct. 19

Frederick

P

**Physician** /Medical **Examiner** 

4a. Facility Name (If not institution, give street and number)

10b. County

5. Social Security Number

189-12-5700

Usual Residence of Decedent

Frederick Memorial Hospital

1**™** M 2□ F

7. Age (In yrs. last birthday)

86

6. Sex

**Funeral** Director

and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examples or marked at

/Medical physician and the burial-transit the attending phed for use as the after death.

I Director: After this certificate has been signed by the series by the series by the grain by filled in by within 24 hours a

To the Funeral C completely 10+1

filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State Frederick Ijamsville Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21754 United States 11609 Primrose Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗹 No 1943 Specify. ģ 3 ⋈ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Defense Mapping Cartographer 12 permit. Pages 1 and 2 should be filled. Department of Health and Mental Hygin Important: If them 27 is marked any injury or other to once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DeSimone Grande Josephine Fredrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11609 Primrose Court, Ijamsville, Md. 21754 Josephine Slovikosky/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 10/1/09 Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee 1050 P. 0. Box 5038, Laytonsville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest shock, or heart-failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of): **Examiner** e 77 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ne IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/10 No 1 ☐ Yes Hospital or Attending Physician: 26. Place of Death (Check onl one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🛮 🛣 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra s Signature

400 W. 7th. Street, Frederick, Md.

State Registrar Myung Hee Nam, M.D.

31. Date filed (Month, Da

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		rtificate d			eg. No. 2009	33039
П	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dear Month	Day Year	3. Time of Death
and the same	/Media	al	MICHAEL WAYN  4a. Facility Name (If not institution, given			4h City Tow	n, or Location of Deat	SEPT.	27 2009 4c. County of Deat	3:50 P M
	Examir	er	Montgomery Gene			01ne			Montgome	
	Funeral		Social Security Number     6. S	Sex 7. Age (In	yrs. last birthday)	If Under 1 Ye	ear If Under 24 Hrs.	(Month, Day	(Year) 9. Birt	thplace (State or Foreign buntry)
	Director		215-62-6437 Usual Residence of Decedent	<b>⊠</b> M 2□ F	56 Yrs.			Nov. 1	8 1952 1	Maryland
	/land ow ≅		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	Md. Montgo	omery	Derwoo	đ				1 □Yes 2 No
	or 28	Dire	10e. Street and Number	Desid		10f. Zip Coo	de 20855	1	0g. Citizen of What Co	•
	s 23a	erai	18401 Muncaster		5-110 49 1	Mac Decedent		Procify Van or No.	United St	
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar mast be realled at	i by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:			of Hispanic Origin? (S Cuban, Mexican, Puerl No Specify:	to Rican, etc.)		
5-(	"natu	letec	15. Decedent's Er (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Oo kind of work do	ccupation one during most of wor stired)	rking	16b. Kind of Business/	Industry
121	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		nce Ins			Fencino	a
	other	Be C	17. Father's Name (First, Middle, Last	)				me (First, Middle, i		
/lar	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Int. Me	면 면	Luther Hedrick	Griffin, Jr	•		Rose	Lee De	Hart	
, Maryland	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship ( Joan L. Kitts-Gra	**					r, City or Town, State, 2 od , Md . 208	
Baltimore,	Pages 1 and 2 nent of Health ant: If Item 27 ary or other tra		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special	Hemovai from State	Ob. Place of Dispo cemetery, crei Salem Co		: -	Date /2/09	20c. Location - City or Brookevi	
Balti	permit. Pages Department of Important: If I any Injury or once.		21. Signatur Funeral/Service Lice	se / 11 - C		Muriel	ddress of Facility H. Barber Box 5038.	Funeral	Home ville, Md.	20882
			23a. Part 7. Enter the disease, or com shock, or heart failure. List only	plications that caused the						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. METASTA	TIC COL	LON	MNCER			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):					
		er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	nsequence of):					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
90,	e exe cian al urial-t		resulting in death) Last	Due to (or as a co	nsequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical		d			· · · · · · · · · · · · · · · · · · ·			
	± 5, α		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy				23d. Date of de	livery
. Box	death cert e attending d for use a	Physician/N	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		☐ Ectopic pregr ☐ Other (specif			Month	Day Year
P.0	at the d	hys	9 Unknown	9 Unknown						
Records,	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	by	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause	e given in Part I.	23e. Did to	bacco use contribute to es 2 No 3 P	robably 4 Unknown
၀၁	law requir as been s 2 should	Completed						24a. Was a	an 24b. Were a	utopsy findings available completion of cause of
<u> </u>	sician: The la certificate ha irector, page 3	Com						perfor	med?   death?	s 2 No
Vita	ician: certific ector,	Be (	25. Was case referred to medical examiner?	Hospital		-1		ath (Check only or	10)	
of Vital	this ald	7: 10:	1 Yes 2 No  27. Manner of Death	Hospital: Inpatient 28a. Date of Injury	2 ER/Outpatie		Other: 4 Nursing I		ence 6 Other (Spe	ecify)
on	Attending in death. ector: After by the funer	ition	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Ye	ar) Injury		Work? 1 ☐ Yes 2 ☐ No	250. 5050/150 //	on injury documed	
Division	al or Atter s after dea I Director d in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, off	ice	28f. Location (S City or Tow	itreet and Number or R rn, State)	ural Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C		nysician: To the best of m niner: On the basis of exa and manner stated.						
	To the comp	Me	29b. Signature and title of certifier			29c. Lie	cense number	2	29d. Date signed (Mon	th, Day, Year)
			I Chihi age	and.		D	42452		September	28, 2005
	2		30. Name and address of purson who				#327			
		10	DE CHITRA RAJAGO 31. Date filed (Month, Day, Year)	32. Registrar's	PRINCE Signature	PHILLP	DR, OLNE.	y mD.	20832	
	Sta		CED 3 0 20	no Aura	. A So	arkel				

		For State Registrar	State of N	Maryland			nt of He te of D		Mental Hy	giene Reg. No.	009	33040
Physic	ian	Decedent's Name (First, Middle, Las     Shawna Sheron (	gray						2. Date of De Month	ath Day 27	2 Year 9	3. Time of Death 12:01 A M
/Med Exami		4a. Facility Name (If not institution, give		er)		4b. Cit	y, Town, or l	ocation of Deat			County of Death	
		Laurel Regional 1	Hospital				Laure				ince Geo	_
Funeral Director		3/6-02-/1/1	x 7 ☐ M 2 1/2 F	Age (In yrs. Ia	st birthday) Yrs.	If Und Months	er 1 Year S Days	Hours Min.				place (State or Foreign ntry) ington, DC
land ow		Usual Residence of Decedent  10a. State 10b. County	<u> </u>	10c. City,	Town or Lo	cation						10d. Inside City Limits
Mary a-f sh	į	MD. Montgome	ery	Roo	ckvill	e						1 ¥Yes 2 No
ith the or 28	Director	10e. Street and Number				10f. Z	ip Code			10g. Citiz	zen of What Cou	ntry?
ath w	ra 	540 Elmcroft Blvd					20850				US	
ite, INIATYIANG ZIZIS-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Expriment mast be notified.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🙀 Divorced	12. Was Decede Armed Force 1 □Yes 2[ If Yes, Give Year or Date	s? XINo		f Yes, sp	edent of His ecify Cuban 2 🙀 No	panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ameri Black, White, Specify: Af 1 Ame	etc.
72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		(Give	kind of v	ual Occupat	irina most of wo	rkina	16b. Kir	nd of Business/Ir	
C Z I Z I	Ig III	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. I	DO NOT	use retired)				D	
C A filled v Hygie ther t		12   17. Father's Name (First, Middle, Last)				bus	Opera		ne (First, Middle		Ride On Surname)	
arylance should be fight and Mental B s marked of umatic eve	To Be	Lorenzo Perkins							line Gra		,	
Maryland 212 Id 2 should be filed within Ith and Mental Hygiene. Zi is marked other than traumatic event, Ins.M.	-	19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	ng Addre	ss (Street a		ural Route Numb		r Town, State, Zi	p Code)
fe, Mal 1 and 2 sh Health an tem 27 is r		Teron Gray / Son			18313	Los	t Kni	fe Circ	le#202 G	aith	ersburg,	MD 20886
ges 1 ar it of Hea if item or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	20b. Pla	ace of Dispo	sition (N natory or	ame of other place	)	Date		cation - City or T	
Pag tment tant:		4 Donation 5 Other (Specify	)		rt Lir	ico1i	1	10/	3/2009	Bren	twood,	MD.
ESITIMOTE, permit. Pages 1 ar Department of He: Important: If item any Injury or othe		21. Signature of Funeral Service Licen	axcis				and Address 31aden		ort Lind d. Brent	oln wood	Funeral, MD.	Home 20722
Physician //Medical Examiner	ш	23a. Par / Enter the dise _e, or comp sc. ck, or heart failu e. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each a. Pulmo:	sed the death. h line. nary Hy as a conseque	yperte			, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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ificate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or	as a consequ	ence of):							
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OT VICAL RECORDS, Physician: The law requires tribis certificate has been signeral director, page 2 should be o	Completed						-		24a. Was auto perfo 1 □ Yes	psy ormed?	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of
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Physic this of	은	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 ☐ Inp 28a. Date of I	atient 2 🔀 E				4 □ Nursing	Home 5 ☐ Resi		, ,	ify)
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month,	Day, Year) Injury - At hor, etc. (Specify	28b. Time o Injury me, farm, str	M		es 2 No	28d. Describe  28f. Location ( City or To	Street an	d Number or Ru	ral Route Number,
e Hospital of 24 hours a: Funeral Dietely filled i	Medical Cer	29a. Certifier 1 CertifyIng Ph (Check only one) 2 Medical Exam	ysician: To the be iner: On the basi and manner	is of examinati	viedge, deat ion and/or ir	h occurre vestigati	ed at the tim	e, date and plac inion, death occ	ce, and due to the curred at the time,	cause(s)	) and manner as I place, and due	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	72	Q.2.	m	2	9c. License	number 2 2 9 6	6	29d. Dat	te signed (Month	
R6		30. Name and address of person who control Thomas H. Burgui	eres. M.	D.			Laure1	Region		tal, Laur	Emerge	ncy Dept. 20707
St	ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signat	re de la	,						

State of Maryland / Department of Health and Mental Hygiene

		1 - State of Maryland	•	tificate of L		Re	g. No U	09	330	Artemotive or the state of the
Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Irene Moulton Gasch				2. Date of Deat Month	Day	Year	3. Time of 1:30	Death P M
/Medi		4a. Facility Name (If not institution, give street and number)		4h City Town or	Location of Death	Septembe	4c. County		1.50	1
Examir	ner	510 Hilltop Lane			liva		Anne		le1	
Funeral Director		5. Social Security Number 026−18−7324   6. Sex 1	st birthday) . Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 2	Year) 0, 1914	9. Birthp Coun Bost	ace (State of try) on, MA	r Foreign
and w		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Loc	eation				10	Od. Inside Cit	v Limits
Maryk f sho	P		.va						1 ☐ Yes	
r 28a	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of V	What Coun	try?	
th witl 23a o set by	<u>a</u>	510 Hilltop Lane		21	140		USA			
er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White, e		
be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, in Medical Evariant unstable resident.	by F	1 ☐ Never Married 2 ☐ Married   1 ☒ Yes 2 ☐ No   If Yes, Give   1944—1   Year or Dates:	.946 1	□Yes 2⊠No	Specify:		Specify	/: Whi	lte	
72 hours aff		15. Decedent's Education	16a. Deced	ent's Usual Occup	ation		16b. Kind of B	usiness/Ind	lustry	
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e filed within al Hygiene.		4	Reg	istered N		/First Adiabatic A	Superv			
8 gr 28	Be	17. Father's Name (First, Middle, Last)  Francis Stanley Moulton				e (First, Middle, M ac Arthu		1e)		
2 should be and Ments is marked aumatic er	10	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	a Address (Street	and Number or Ru			State. Zip	Code)	
and 2 sh and 2 sh lealth and m 27 is n her traun		Kay J. McIntire / Friend		,	Drive,			, ,	,	
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nit. Pages artment of ortant: If Ite injury or o		1 M Buriai 2 Li Cremation 3 Li Removal from State 1		ln Cemeter		/2009	Brentwo			
permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any liqury or other traumatic once.		21. Signature of Funeral Service Licensee  H Con Stance Jase	1	. Name and Addres asch's Fu	ss of Facility ineral Ho	me, P.A.			nore A e, MD	
		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Bety	een .
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the d	Jysid	1   Yes 2   W6   4   Fregnant at time of de 9   Unknown	- U							
s that gned b	by PI	Part II. Other significant conditions contributing to death but not result		nderlying cause give	en in Part I.	23e. Did tol	oacco use con	tribute to th	ne cause of d	eath?
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ne law requires has been sign ge 2 should be	Completed					24a. Was a autops	v l	Were auto	psy findings a	available ause of
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Attending or death. ector: After by the fune	tior	1 → Matural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	Injury	Work	k? Yes 2 ∐No		, ,			
lor Atte after dez Directol	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At how building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (St City or Town	treet and Numb n, State)	per or Rura	l Route Num	ber,
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my know and manner stated.								.)
Fo the vithin or the comple	Mec	29b. Signature and title of pertifier		29c. Licens	e number	2	9d. Date signe	ed (Month,	Day, Year)	
->-0		· CAS		D5	1628	0	ont =	28.	200	9
1041		30. Name and address of person who completed cause of death (Item	- :	1 0	0. 0		Apr. 6	~ 0		
		Haitya Chopra M.D Ga		zely Av	e Ste 2	31 Ann	apolis	5 M	1160	01
Sta Regist		31. Date filed (Wonth, Day, Year)  32. Registrar's Signat	ure .				4			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sara Ida McMurry Greenwell October 5<sup>Day</sup> 2009<sup>eai</sup> 8:58 Рм Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death
Middletown 4c. County of Death Frederick **Examiner** 2623 Marke Road 5. Social Security Number 8. Date of Birth (Month, Day, March 19, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours 406-32-8160 Kentucky 82 **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Frederick Middletown 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 21769 United States 2623 Marker Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exal Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>it</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Estelle Mauzy George Thomas McMurry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2623 Marke Road, Middletown, Maryland 21769 19a. Informant's Name/Relationship (Type, Print) William Greenwell / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 13, 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Smithsburg Crematory 2009 Signature of Funeral Service Lice <sup>22, Name and Address of Facility</sup>
Keeney & Bastord P.A. Funeral Home
106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ~ WNG Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Satural 24 hours after death. Funeral Director: After (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

3 🗆

th, Day,

Year)

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title of certifier

31. Date filed (Month,

DHMH 17 Rev 7/2009

DIC

within 2 To the

egistrar's Signature

29c. License number

MO 51610

21702

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		<ul> <li>State Registrar AMEND#19aperFH</li> </ul>	9-30-09.FMW.M	m C	ertificate of D	eaui		g. No.			
		1. Decedent's Name (First, Middle, Last)		<u>~</u>			2. Date of Death Month	n Day	Year	3. Time of Dea	
Physicia		M	arion C. Hard	iy				ber 25, 2		1550	
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County	of Death		
- Xullill		Montgomery Gener	al Hospital			01ney			Montgo		
uneral		5. Social Security Number 6. Sex		rs. last birthda	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Coun		
rector		579-18-1745	141 2 F	88 Yrs.			December	23,1920	North	n Carolina	a_
>	]	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or	Location				10	0d. Inside City L	Lim
sho at at	5			**		olumbia				1 ☐ Yes 2	X I
28a-1	Director	Maryland Howard  10e. Street and Number	1		10f. Zip Code	OTUMDIA	1	0g. Citizen of \	What Coun	itry?	
la or			a Cara			21044			U.S.	Α.	
ns 23	era	6513 Ranging Hi11  11. Marital Status	12. Was Decedent Ever in	n U.S. 1:	3. Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		ce - Americ	can Indian,	
of other than "natural", or items 23a or 28a-f show event, the Musical Examinat must be mutified at	Funeral	1 Never Married 2 Married	Armed Forces? 1    Yes 2   No		If Yes, specify Cubar		Rican, etc.)		ck, White, e	etc.	
o'.'le	ğ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: <b>1942</b>	-1946	1 □Yes 2 🛣 No	Specify:		Specif		Caucasian	1
ical	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. De	cedent's Usual Occupa	ition Jurina most of work		16b. Kind of B	usiness/Ind	dustry	
an "r	lg l	Elementary/Secondary (0-12)	College (1-4or 5+)	- \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	e. DO NOT use retired,	)				. D. C	
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d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			ne)		
arked atic e	2	Curtis Ha	ırdy	_			Mary			0 (10 10)	
item 27 is marked other than other traumatic event, In M.		19a. Informant's Name/Relationship (7)	ype. Print)		ailing Address (Street a					) Code)	
item 27 is r other trau		Celeste A. Sims -C	Guardian		3 Ranging Hil			20c, Location		own State	_
ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, c	sposition (Name of crematory or other plac			ZOC. LOCATION	Oily Of To	7411, Otalo	
ant:		4 □ Donation 5 □ Other (Specify)		Ft. Linc	oln Crematory		0/2009	Brentwoo	od, Mai	ryland	
Important: If it any injury or o		21. Signature of Funeral Service Licens	me 0 1	101054	22. Name and Addres Hines-Rinal 11800 New H	di Euneral	Home, Inc venue, Sil	ver Spri	ing, Ma	aryland 20	.09
		23a. Part 1. Enter the disease or comp	lications that caused the	death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between	eer
sician		shock, or heart failure. List only o Immediate Cause (Final	-		`^				- 1	Onset and De	atr
edical		disease or condition resulting in death)	a. Due to (or as a con	sequence of):							_
miner			, Anae	4.00							
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	nsequence of):							
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ng physician and as the burial-transit		resulting in death) Last	Due to (or as a con	sequence of):	boillation Disad						
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ng F	5	23b. Was decedent pregnant	23c. If yes, outcome of pre	Adnancy .							ear
tending print use as	_ C		1 Live birth 2	Fetal death	3 Ectopic pregnanc	У		L .	ate of deliv		
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State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / De State Of Registrar	epartment of F Certificate of I			ene g. No. (2009)	33044		
	Physicia		1. Decedent's Name (First, Middle, Last) Brereton Gilbert Hughes			2. Date of Death Month Septemb	er 30, Year	3. Time of Death 09 4:25 aM		
***	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital	4b. City, Town, or	Location of Death		4c. County of Dea			
ang)	Funeral Director		5. Social Security Number   6. Sex   7. Age (In yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	9. Bir	thplace (State or Foreign ountry) ryland		
	/land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	r Location		10d. Inside City Limits				
	a-fsk	ctor	Maryland Montgomery S	Silver Spri	ng			1 □Yes 2X No		
	th the	Director	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Co	ountry?		
	s 23a		3242 Gleneagles Drive, Apt. 2F		20906	7 V N	USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Eventinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ② Wildowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes ② ② ③ X No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify Whi	e, etc.		
21215-0036	2 hou	ted	15. Decedent's Education 16a. D	ecedent's Usual Occup	ation	16	6b. Kind of Business			
215	hin 73 e. an "n Medi	ple	(Specify only highest grade completed) (C Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done of the DO NOT use retired	during most of work d)	ing				
7	ygien ygien ier th	Completed	1	Government		<u> </u>		hone Company		
Maryland	be filk	Be	17. Father's Name (First, Middle, Last)  Gilbort William Hughes			e (First, Middle, Ma	•			
<u>₹</u>	d Mer narke	은	Gilbert William Hughes			izabeth		7. 0.4.		
Mai	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (Type. Print) - Daughter 19b. N				-			
é,	1 and Healt tem 2			Varnum St isposition (Name of crematory or other place			Dc. Location - City or			
Baltimore,	Pages ment of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of	crematory`or other place Heaven Ce		t. 6		ing,Maryland		
Ball	permit Depart Import any In		21. Signature of Funeral Service Licensee	22 Name and Addre Francis J 500 Unive	ss of Facility . Collins rsity Bly	Funeral	Home Inc ilver Spr	ing, MD 20901		
68760,	hiticate be executed by Physician and by physician and by physician and as the burial-transit	ledical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  Due to (or as a consequence of)	failure	J AIR	S				
P.O. Box	The law requires that the death certificat ate has been signed by the attending phy agge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the past 12 months?	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)		23e. Did toba	23d. Date of de Month	elivery Day Year to the cause of death?		
ds,	uires t signe Id be o	d by				1 □ Yes	2 No 3 P	Probably 4 X Unknown		
Vital Records,	Physiclan: The law req r this certificate has beer ral director, page 2 shou	Completed				24a. Was an autopsy performe	ed? prior to death?	utopsy findings available completion of cause of		
/ita	clan: ertific ctor,	Be	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)				
	Physic this or	ဥ	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp	<del></del>	4 LI Nursing Ho		ice 6 ☐ Other (Spe	ecify)		
ř	d <b>ing P</b> h. After t	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Inju	iry Wor	k?	28d. Describe how	injury occurred			
Division of	or Atten ifter deat Director: in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (	29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, of the basis of examination and/one and manner stated.							
	To the within To the comp	Me	The second secon	29c. Licens	9247		d. Date signed (Mon	100		
	3		30. Name and address of person who completed cause of death (Item 23a) (Ty  Mohamed Tour 145 7	rpe, Print) 300 Van	Dusan	Rd. La	rurel, mi	20707		
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	bares						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:20AM 4c. County of Death 4b. City, Town, or Location of Death (If not institution, give str 4a. Facility Nam ome Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y June 22, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Year Months Days 1**X** M 2□ F Virginia 67 1942 224-46-2953 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Adelphi Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20783 9709 24th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 11 Marital Status Black, White, etc. 1 Never Married 2 Married Yes, Give Year or Dates: 1960-64 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rosa Taylor Junius Hayes, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9709 24th Avenue, Adelphi, Maryland 20783 Carolyn Hayes/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State October 6 Veterans Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) Cheltehnam, Maryland 2009 Francis AdressColllins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Fuperal Service Licensee MD 20901

**Physician** /Medical Examiner

**Physician** /Medical

Examiner

Director

Funeral

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Be Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural" ~ " any injury or other traumatic even."

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and Sician ate has been signed by the atte page 2 should be detached for After

Hospital or Attending Physicien: The law requires that the death certificate be executed thours after death.

Funeral Director: Af
ely filled in by the fu within 24 hours a To the Funeral E

Division of Vital Records, P.O. Box 68760,

3+1

DHMH 17 Rev 1/2001

	23a. Part1. Efter the disease, or conshock, or heart failure. List on	mplications that caused the death. Do not enter the mode of dying, such as cardiac ly one cause on each line.	or respiratory arrest,	Interval Between Onset and Death
	Immediate Cause (Final disease or condition	Cerebrovascular Accident		Minutes
	resulting in death)	Due to (or as a consequence of):		
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or se a consequence of):		
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.  Due to (or as a consequence of):		
edicai		d		
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
h Ph	Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
d b	Dementia, Lewy B	ody Type	1 ☐ Yes 2	No 3 Probably 4 Unknown
Completed by	Parkinson's Dise	ease, Atrial Fibrillation,	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Con	Hyperlipidemia		1 Yes 2 No	
Be (	25. Was case referred to medical examiner?		th (Check only one	
O	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence	6 ☐Other (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

completed cause of death (Item 23a) (Type, Print) an, MD 9801 Georgia Avenue, #1-17, Silver Spring, MD 20902

1 ☐ Yes 2 ☐ No

D53367

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) September 30, 2009

31. Date filed (Month, Day, Year) -

30. Name and address of person wi Shyamsundar Rajan,

27. Manner of Death

1 X Natural

2 Accident

4 - Homicide

(Check only one)

29b. Signature and wife of co

3 Suicide

29a. Certifier

5 Pending

investigation

6 ☐ Could not be

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

Certification:

Medical

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) r 30, Year 2009 Month **Physician** 10:20 a<sup>M</sup> September Delores Jeanette Hartley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House 8. Date of Birth (Month, Day, Year) June 26, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🛣 F Maryland 87 577-26-3718 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 □Yes 2X No Director Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #2E United States 3505 South Leisure World Boulevard, 20906 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: Caucasian <u>6</u> 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Its. Fauls once. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Anna Mae Powell George Hanson Green ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Manor Way, Cape Elizabeth, Maine 04107 Karen H. Landis / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 10/01/2009 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Thibadeau Mortuary Service, P.A. 933 Gist Avenue, LL, Silver Spring, MD 20910 1100 M00956 23a. Part 1. Mer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** METASTATIC BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and burial-trar Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the as IF FEMALE for use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 X No P.O. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown HYPERTENSION funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPOTHYROIDISM autopsy performed? Yes 2 XNo has certificate 1 ☐ Yes 2 ☐ No 1 Yes DEMENTIA e Hospital or Attending Physician: 24 hours after death.
9 Funeral Director: After this certificately filled in by the funeral director, p. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other:  ${}_{4}\square$  Nursing Home  ${}_{5}\square$  Residence  ${}_{6}$  X Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 27. Manner of Death 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kouatchou, ms D 63 740 P. SEPTEMBER 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOCELYNE KOUATCHOU, M.D., 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD 20855 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

01 2009

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Day 10:45

 $A^{M}$ 

Birthplace (State or Foreign Country)

Thomasville, GA

Specify: Black

29d. Date signed (Month, Day, Year)

10d. Inside City Limits

Onset and Death

1 XYes 2 No

1. Decedent's Name (First, Middle, Last) **Physician** EDWARD HARRISON 9/22/2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE"S PRINCE GEORGE"S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Months Hours 1 **X**M 2 □ F Yrs 5/15/1921 Director 578-12-0562 88 Usual Residence of Decedent 10c, City, Town or Location 10a. State 10h. County and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evantines in ust be a difficillated. Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 5012 Ames Street NE 20019 United States Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 No If Yes, Give 11. Marital Status hours after 1 ☐ Never Married 2 🕏 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: \$ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation filed within 72 h 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Public Schools 8 Head Custodian 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) unk Be Evelyn Harrison ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen H. Harrison / Wife Ames Street NE Washington, DC 20019 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/29/2009 4 □ Donation 5 □ Other (Specify) Landover, Maryland Harmony Memorial 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service License 5538 Marlboro Pike Forestville, Maryland 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** FATAL CARDIAC ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a P.O. I 1 Tyes 2 TNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by this certificate has been sail director, page 2 should 24a. Was an To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1∐ Yes 2% No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day, Year) 5 ☐ Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 212 No 1 ☐Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

29c. License number

State Registrar Kisha Chase MD 123 45th Street NE Washington, DC 20019 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day,

09-075	80	
Bobby	Lee	Haynes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2019 13013 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day Y September 25, 2009 Physician/ 2348 hrs Medical Examiner Bobby Lee Haynes 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Capitol Heights 6929 Bank Run Terrace 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Min Months Davs Hours 05/22/1954 DC 579-72-1459 55 Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ξý 10a State 10b County 1 X Yes 2 No 28a-f show District Heights Maryland Prince George ITMORE, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other and a control of the control of th or items 23a or 28a-f show must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 6929 Bankrun Terrace 20747 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 Never Married 2 X Married 2 X No Yes Afro-Specify: American If Yes, Give Year 1 Yes 2 X No specify: Widowed Divorced traumatic event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) Complet Private Manager 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Nannie Bell Thomas Be James Haynes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type, Print) Michelle Haynes Bey/ Wife 6929 Bankrun Terrace District Heights, Md. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, other t crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3, 2009 Important: Landover, Maryland Harmony Memorial Donation 5 Other Specify ō 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Washington, DC 4001 Benning Rd. NE 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and lure. List only one cause on each line. /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED attending physician for use as the burial UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 V No 3 Probably 4 Unknown <u>გ</u> Completed Records. 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Division of Vital Other<sub>4</sub> Residence 6 Other: Scene Hospital: Nursing Home 5 ER/Outpatient 3 Inpatient this ٩ 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Certification: Subject shot Sep 25, 2009 2335 hrs Yes 2 V No Natural Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 6929 Bank Run Terrace, Capitol Heights, MD Suicide (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. September 26, 2009 e 18 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 32. Registra s Signa State

Registra DHMH 17 Rev 1/2001

OCME

			For State Registrar	State	of Maryla		artmer r <i>tifica</i> i			ind M		giene Reg. No.	201113	9	3304.9
Н			Decedent's Name (First, Middle, L.	.ast)							2. Date of De Month		. V		3. Time of Death
	Physici /Medic		ESTELLA		HUNTER						SEPTEM	IBER	25 200		10:04 A <sup>M</sup>
	Examin	-	4a. Facility Name (If not institution, g.	ive street and nu	umber)		4b. City	, Town, or	Location o	f Death		4c.	County of De	ath	
		Ā	WASHINGTON ADV	ENTIST	HOSPITA	.L			A PARI				ONTGOME	ERY	
	Funeral Director		217~32-0971	Sex 1 □ M 2 🛣 F	7. Age (In yrs	. last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da SEPT 5	th y, <i>Year)</i> 193		Counti	ace (State or Foreign ry) LAND
:15	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10	d. Inside City Limits
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	ē		GEODGE											1X Yes 2 □ No
	the N 28a-f lotific	Director	MD PRINCE  10e. Street and Number	GEORGE	S	FOREST		p Code				10a Citi	izen of What	Count	rv?
	with a or	흅	3409 REGENCY P	VERTIVA			101. 21	2074	4.7				JSA	Journ	.,,.
	eath	Funeral	11. Marital Status		cedent Ever in	J.S. 13.	Was Dece			nin? (Spe	cify Yes or No		14. Race - Ar	nerica	n Indian,
	fter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed F 1 ☐ Yes	orces? 2 📉 No					, Puèrto l	cify Yes or No Rican, etc.)		Black, Wi		
36	urs a	þ	3 X Widowed 4 ☐ Divorced	If Yes, G Year or I	iive		1 ☐ Yes	2X No	Specify:				Specify:	BL	ACK
215-0036	n 72 hours after death with the Manylan "natural", or items 23a or 28a-f show adical Examiner must be notified at	Completed	15. Decedent's	Education	1	16a. Dece	dent's Usu	al Occupa	ation	t af markin		16b. Ki	ind of Busines	s/Indi	ustry
2	within 72 ene. than "nai he Medic	ple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT L	ise retired	during most I)	OF WORKI	ig				
7	filed wil Hygien other th ent, the	Son	12TH			NI	JRSIN	G AS					PRIVATE		
2	be filed within 72 ho ital Hygiene. Id other than "natul event, the Medical	Be (	17. Father's Name (First, Middle, Las	•	-						(First, Middle		,		
₹		ဥ	JAMES ROBERT M		K.	1				IDA		ALLE			
Maryland	C1 10 10 10		19a. Informant's Name/Relationship	(Type. Print)							l Route Numb				Code)
	s 1 and if Health item 27 other to		THOMAS A. HUNTER  20a. Method of Disposition	JR./SO	N lanh	3409	REGE	NCY I	PARKWA		ORESTVI		MARYLA ocation - City		20747
وّ	e = t e		1 Durial 2 Cremation 3			Place of Dispo				_			,		,
aitimore,	it. Pa rtmer rtant njury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lit		н	ARMONY			ss of Facilit		/2009		VDOVER,		
g	permit. Pag Departmen Important: any injury once.		21. Signature of different Bernes Ele	ensee	_						LANDOV				AL HOME
			23a. Part1. Enter the disease, or co	mplications that	caused the dea								1211(1.1121)	-	
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on	each line.	ĺ	. ^				la				Approximate Interval Between Onset and Death
3	Physician /Medical		disease or condition resulting in death)	a. Duo ta	o (or as a conse	Val	ve	er	do	co	route	9	Unit 1	-	
	Examiner		- 1	F	mhal	ic C	NE	av re	1/20	Cor	lar c	2001	dout	-	
ġ.		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a conse	quence of):	VVC	210	VCC.	scac	acor -		CC CVV	-	
	d d ansit	Examine	Cause (Disease or injury that initiated events		=nd &	stage	2 Y	en	a)	die	lasc	)			
Ď,	exec an an rial-tr	Exa	resulting in death) Last	Due to	(or as a conse	quence of:									
09/8	the death certificate be executed y the attending physician and iched for use as the burial-transit	dical		d	bu ak	setes	,							_	
٥	ng ph	Med	IF FEMALE:											1	
ŏ R	leath certific attending p	an/I	23b. Was decedent pregnant		utcome pf pregion birth 2  Fe		∃Ectopic p	regnancy				1	23d. Date of o		y Day Year
5	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preç 9□Unk	gnant at time of nown	death 5	Other (s	pecify)					WOILLI		Day Teal
<u>.</u>	w requires that the d been signed by the should be detached	Physician/Me	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying	cause nive	an in Part I		23e Did t	ohaccou	use contribute	to the	e cause of death?
ecords,	The law requires that te has been signed b age 2 should be deta	Ď	Tak II. Odlor signilosiii ooliotoo	o continuating to	additi bat itot to	outing in the u	naonymy	oudoo giii	on mr air.						ably 4 🖾 Unknown
Ö	requ	Completed									-				
é	e law has b	npl du						_			24a. Was		24b. Were prior t death	autop o con	sy findings available pletion of cause of
<u>=</u>											1□ Yes	2K No	1 TY	es :	2 💢 No
VITAI	Physician: The law r this certificate has L ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				OA Othe	or.		(Check only o				
Ö	Phy r this ral d	- To	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 . 1	Inpatient 2[ e of Injury	ER/Outpatier 28b. Time o		٠^	4 □ Nu		ne 5 Resi 28d. Describe			pecify	)
	ding J. Afte fune	tion	1 Natural 5 Pending 2 Accident investigati	(Mo	nth, Day Year)	Injury	м .	28c. Injun Worl	k? Yes 2 ⊟ l		ed. Describe	now injui	ry occurred		
UIVISION	I or Attending after death. Director: Afte I in by the fune	fica	3 Suicide 6 Could not	to a	ce of injury - At l	home, farm, str					28f. Location (	Street ar	nd Number or	Rural	Route Number,
5	i ji fi	Certification:	4 ☐ Homicide determine	u buile	ding, etc. (Spec	cify)					City or To	wn, State	9)		
	Hospital or A 24 hours after of Funeral Direct etely filled in by			Physician: To th											
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only 2 Medical Ex		basis of examir nner stated.	nation and/or in	vestigatio	n, in my o	pinion, dea	ith occurr	ed at the time	date an	a place, and o	ue to	tne cause(s)
	To the within 2 To the complex	Ž	29b. Signature and title of certifier	1			29	c. License	e number			29d. Da	te signed (Mo	onth, L	Day, Year)
			1010	dn	9	MO		D	338	339	7		1/26/	0	9
0	3		30. Name and address of person wh		,	, , , , .								.01	7
			PADMA CHIRUMA				JLL A	VENU	L TAK	UMA ]	PAKK, M	IARYI	LAND 20	191	
estic.	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	externature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Joseph Howard Hannah Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First Middle, Last) Joseph Howard Hannah Physician/ Month Day October 7, 2009 1103 hrs **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Caroline Denton 2437 Pealiquor Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Foreign Country) NY Hours Days Months 01/16/1935 Director 085-28-6456 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a State 10b. County Yes 2 No Caroline MD Denton d other than "natural", or items 23a or 28a-f show. . he Medical Ex miner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21629 24737 Pealiquor Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Caucasion itimore, MD 21215-0036

ii. Pages I and 2 should be filed within 72 hours after dea
wrant: Or Health and Mental Hygiene.

rrant: If item 77 is marked other than "natural", or it
y or other traumatic event, the Medical Ex. miner mus 1 X Yes Yes 2 X No specify: Give Year Divorce Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed State Elementary/Secondary (0-12) College (1-4 or 5+ Personnel Director 12 Hospitals 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McDonnell Annie Joseph Patrick Hannah Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) NC 27520 206 Bee Lane, Clayton, daughter Barbara Watts / 20c. Location - City or Town, State Date 20a. Method of Disposition

1 Burial 2 X Cremation 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 10/9/09 Dover, DE Capitol Crematory tant: Other Specify Donation 5 22. Name and Address of Fac onature of Funeral Service 2nd st. D 21629 12 S. Moore Funeral Home, P.A., 1004 MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and one cause on each line failure. List only Death /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **xamine** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED **AMENDED** 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months' Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown þ 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy

The law requires that the death certificate be executed s been signed by the attending physician should be detached for use as the burial Records, P. Completed certificate has b To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi **Division of Vital** Be this dir 2 Certification: I Director: ed in by the f

death? performed? 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) Other<sub>4</sub> Hospital: 1 Residence 6 V Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Yes 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) determined

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

of person who completed cause of death (Item 23a) Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

31. Date filed (Month, Day, Year, State Registrar

Pamela E. Southall, MD

25. Was case referred to medica

No

Pending

examiner?

1 Yes

27. Manner of Death

Accident

Suicide

Homicide

1 V Natural

2

3

32/ Registrar's Signature

16

October 8, 2009

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Gupta

Ken

625

32. Registrar's Signature

29c. License number

D0033280

29d. Date signed (Month, Day, Year)

Ave. Cumberland, MD. 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas Hunt Henry 0100 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegan 5. Social Security Number 6. Sex umberlan Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Hours **X**□ M 2□ F 215-20-5196 March 21,25 Maryland **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Director MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Ren Roy Drive 21502 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1943 1 ☐ Yes 2 🛣 No Specify: \$ 3 Widowed 4 Divorced White 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Manager Bakery 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Robert Vance Hunt Mary (Tighe) Hunt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita June Hunt 25 Ren Roy Drive, LaVale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Mem Pk Oct 12 09 Frostburg, MD 22. Name and Address of Facility Signature of Funeral Service Licenses Hafer Funeral Service, P. Hwy., LaVale, MD 21502 1302 National Hwy., LaVale, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** synchroma one da sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Disease Renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No autopsy perform 2 No I□Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. Division of Vital Records, The law requires

that the death certificate be executed ettending physician and for use as the burial-transit After this certificate has been signed by the funeral director, page 2 should be detached Physician: Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur

28a-f show

? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner must be notified at

e filed within 72 hours after dal Hygiene.

and Mental Hygivis Is marked other

Baltimore, Maryland 21215-0036

determined

4 ☐ Homicide

29a, Certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Nonsochst

D0055325

08, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Cumberland MD 21502 Walch Rd WONSOCK 925 Bishop SHIN

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 15 2009 32. Registrar's Signature Back

6+1 DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Depar State of Maryland / Depar Registrar Certification	ificate of I		, ,	eg. No.	5 00000
			Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Time of Death
Н	Physici /Medio		HENRY JAMES KOSH			Month Septemb	per 21 09	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of Death	-	4c. County of De	ath
1			13109 Estelle Road	Silver			Montgome	
	Funeral		1 □ M 2 □ F	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	<ol><li>Date of Birth (Month, Day,</li></ol>	Year) (	lirthplace (State or Foreign Country)
	Director		218-16-0036 85  Usual Residence of Decedent			4/17/24	MI	)
	/land		10a. State 10b. County 10c. City, Town or Loca	tion				10d. Inside City Limits
	Mary 19-f sh	ģ	MD Montgomery Silver Spr	ina				1 □Yes 2XX No
	n the	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What (	Country?
	th wit		13109 Estelle Road	20906			USA	
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa Armed Forces?	as Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Ar Black, Wh	merican Indian,
36	or it	by Fi	1 Never Married 2 X Married 1 XYes 2 No 1943 − If Yes, Give	⊒Yes 2. No	Specify:		Specify:	110, 610.
Ö	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examilian must be notified at	g p	3 Li Wildowed 4 Li Divorced Year or Dates: 1945		-41	- 10	B.	lack
21215-0036	in 72 " ra" r	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occup nd of work done of NOT use retired	during most of workir	ng '	6b. Kind of Busines	s/industry
212	with jiene	E O	Elementary/Secondary (0-12) College (1-4or 5+) Porter		~	E	Tuneral	
	al Hyg othe	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name			
Maryland	uld be Mentz rrked tic ev	70 E	Charles F. Kosh, Sr.		Emma How	ard		
ar	and Isma			City or Town, State	, Zip Code)			
	of Health a item 27 Is			<u>.</u>	Laurel, M	D 20707		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examinations to notified at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, crematical control of the complete o	ion (Name of tory or other plac	ce) D	ate 2	20c. Location - City of	or Town, State
Ë	Pag tment tant: jury		4 □ Donation 5 □ Other (Specify) Bushy Park	c Cem.	10/3		Cooksville	
3ali	permit Depar Impor any in once.		No. 1 State of the state of the		ss of Facility Sno			
	ED = 40				hington S			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dyin	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
8	Physician		Immediate Cause (Final disease or condition resulting in death)  a. 15 CV D					Dine
ed.	/Medical Examiner		Due to (or as a consequence of):					1000
		er	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events c.					
ó	ifificate be executed by physician and as the burial-transit	Еха	resulting in death) Last  Due to (or as a consequence of):					
68760,	ate be nysici he bu	ledical	d					
			IF FEMALE:					
Вох	attendin for use	sician/N	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy	y		23d. Date of c	
0	the a	sici	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   C	Other (specify)	,		Month	Day Year
P.0.	that the dended by the detached	Phys	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause give	en in Part I	23e Did tob	acco use contribute	to the cause of death?
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COL	v requ been shoul	ete				24a. Was an	24h Wara	autoney findings available
Re	The law cate has page 2 s	Completed				autopsy	prior to	autopsy findings available o completion of cause of ?
ta	ician: Th certificate rector, pag	a)	25. Was case referred to medical		26. Place of Death	perform		es 2 No
$\leq$	Physician: this certifica al director, p	. B	examiner?  1  Yes 2 □ No  Hospital:  1 □ Inpatient 2 □ ER/Outpatient	3 □ DOA Othe	~		nce 6 ☐Other (Si	necify)
0	ding Ph h. After th funeral	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury Work	y at 2		w injury occurred	/cony/
Θ	endir eath. or: At	atic	2 Accident investigation		Yes 2□No			
Division of	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	2	28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	pital ours a sral Deral Cilled		200 Costilios				4.5	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death o (Check only one)  1 Medical Examiner: On the basis of examination and/or investant manners stated.	stigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	tuse(s) and manner ate and place, and d	as stated. ue to the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License	e number	29	d. Date signed (Mo	nth, Day, Year)
			mm S de Lu mo OME	かっ	10428	5	Up 29	2009
	5		On Name and address of service with a service of death (Name One) (Time Bei	2 6 11-1	a man A M	cal p	19 29	1
			31. Date filed (Month, Day, Year)  SEP 30 2009	511	U21 50	7 7	mo	5000
	Sta		31. Date filed (Month, Day, Year)  37. Registrar's Signature	19				
*	Registra	ar	SEP 3 0 2009 Certus B. Jack					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 7:40 DM Kyoo Hwa Kim September 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7070 Cradlerock Way, #328 Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Min. **Director** 216-15-2157 71 October 8, 1937 Korea Usual Residence of Decedent filed within 72 hours after death with the Marvland 10a State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating the notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7070 Cradlerock Way, #328 21045 II.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No ≥ Specify Specify: 3 Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygier is marked other th 4 Building Manager Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int; If item 27 is marked of Dol Sok Kim Kye Soon Yoon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Kim - Son 12193 Cambourne Terrace, Fairfax, VA 22030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important; If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State / injury 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 09/30/2009 Olney, Maryland 21. Signature of Funeral Service Licensee MOIOZA 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the direas shock, or heart fature. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest st only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be execut and Due to (or as a consequence of): burial-Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s page this certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the funeral 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending Injury To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type North Dr. 5.140 Columbia MD 21045 450 31. Date filed (Month, Day, Year) Registrar's Signatur

Registrar

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Approximate Interval Between Onset and Death

415 East Wilson Blvd., Hagerstown, Maryland 21740

	1	State Registrar						(	Cer	tificate	of I	Deati	h		Reg.	No.		33000
Physician /Medical		1. Decedent's Name	e (First, Middl Mar			elyr	n KE	NT						2. Date of D Month Octobe		Day 200	)9 <sup>Year</sup>	3. Time of Death 8:45 p M
Examiner		4a. Facility Name (f 913 Mar				umber)						town	n of Death	1		4c. Count Was	y of Deat	
Funeral Director		5. Social Security N 216–14–6	152	6. S	ex □M 2∏gF	7. Age	e (In yrs. la	ast birth 87 Y		If Under Months	1 Year Days	If Undo Hours	er 24 Hrs. Min.	8. Date of B (Month, D Jan•	ay. Ye	1922	9. Birti Co Mar	nplace (State or Foreign unity) y Land
O		Usual Residence of	Decedent															
Marylan -f show led at	١,	10a. State Maryland	10b. County Wash		ton		10c. City Ha	, Town lger										10d. Inside City Limits 1   Yes 2   No
fter death with the Mar r Items 23a or 28a-f sl uner must be notifled		0e. Street and Number 913 Marion Street								10f. Zip Code 21740 10g. Citizen of Wh						What Co	untry?	
al",o		11. Marital Status  1 □ Never Married 2 □ Married  3 □ XWidowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ X No If Yes, Give Year or Dates:					S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes 2☑ No Specify:  11□ Yes 2☑ No Specify:  12□ Yes 2☑ No Specify:  13□ Yes 2☑ No Specify:  14□ Race - American Indian, Black, White, etc.  Specify: White						e, etc.				
"natur dical		15. Decedent's Education (Specify only highest grade completed)						16a. I	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b	16b. Kind of Business/Industry			
ed within 72 ho ygiene. her than "natur: ft, the Medical E		Elementary/Seco	, , ,		College 0	(1-4or 5	+)		homemaker her own					wn h	ome			
Mental Hyg Mental Hyg arked othe atic event,	2	17. Father's Name (First, Middle, Last) Harlen T. Rider							18. Mother's Name (First, Middle, Maiden Surname) Lula A. Gruber									
und 2 shou alth and Iv 27 Is ma or trauma		19a. Informant's Na Susan Ho				nter		19b. 11	Mailin 41	g Address 5 Dro	(Street P Ro	and Nun	will	iral Route Num iamspor	ber, Ci	ty or Towr Mary	State, 2 Land	21795
Pages 1 and of He nort of He nort: If Item Iny or other		20a. Method of Disp 1 ⊠ Burial 2 4 □ Donation	☐Cremation			n State				sition <i>(Nan</i> natory or o 1 Cem		ce) Y	0cto	ber 6,			•	Town, State , Maryland
permit. Departn Importa any inju		21. Signature of Fu	uneral Service	_						Name an <b>Eas</b>			,	Minnich d., Hag	_			ne ryland 2174

**Physician** /Medical

Baltimore, Maryland 21215-0036

Examiner

physician and s the burial-trans

as

use

After this certificate has been signed by the funeral director, page 2 should be detached

Be Completed by

2

Medical Certification:

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

ithin 24 hours after deam.

o the Funeral Director. Aft

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

23b. Was decedent pregnant

in the past 12 mor

25. Was case referred to medical

2<del>0</del> No

9 Unknown

IF FEMALE:

Immediate Cause (Final disease or condition resulting in death)

,	Due to (or as a consequence of):
С.	
	Due to (or as a consequence of):
d	

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

U as

Due to (or as a consequence of):

23d. Date of delivery Month Year Day

Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. USLLEWSLA

Hospital: 1 ☐ Inpatient

3e. Did tobac	co use con	tribute to the cau	use of death?
1 Tes	2 No	3 Probably	4 □Unknow

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes

<ol><li>Place of Dea</li></ol>	ith (Check only one)
her: 4□ Nursing H	ome 5 Hesidence 6 Other (Specify)
ıryat ork? ]Yes 2∐No	28d. Describe how injury occurred
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

27. Manner of Deat 1 ☑ Natura! 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac fy)	tory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only						e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

2 ER/Outpatient 3 DOA

1	and manner	/otatou:
29b. Signature and title of certifier	/	
	116	

29d. Date signed (Month, Day,

	( )										- 4
30.	Name and a	address	of person	who	comp	oleted	cause	of death	(Item 23a)	(Туре,	Print)

5 111

06

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1444 AM 14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 216-31-4851 1 □ M 2 🕱 F Hours Min 98 (Month, Day, Year) 09/24/1911 Director Guyana Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Prince George's Adelphi |Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20783 USA 9612 Riggs Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗶 No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dress Maker Self Employed 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mitilene Allicock Daniel Delpesh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Kendall/ Granddaughter 9612 Riggs Road, Adelphi, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Important: It any injury or permit. Page Department George Washington 10/05/2009 Adelphi, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, . Signature of Luneral Servi Licer 20019 4001 Benning Rd., NE, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed iis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 X No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 X Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛚 Natural 5  $\square$  Pending work? 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of of 29d. Date signed (Month, Day, Year) 3:10

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arro

mith

Date filed (Month, Day, Year)
OCT 0 2 2009

### 09-07676

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam P. Knotts	1-	State of Maryland / Department of Health and Mental H	lygiene		2.0	110	3305
Physician/	Re	edistrar Decedent's Name (First, Middle,Last)	2. Date of	Reg. No f Death		3. Time	of Death
Medical Examine		William P. Knotts	Octob	er 2, 20		2145	5 hrs
	48	a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	h	ŀ	4c. County of D Allegany	Death	
	Ļ	Western Maryland Health System Braddock Campus  Cumberland  Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs	s 8 Date	of Birth (M		J. Birthplace (S	State or Foreign
Funeral Director	5.	Months Days Hours Min	n.		1960	Country)	
Director	L	187-56-6729 1 X M 2 F 48 Yrs.	Dec	. 10	, 1900	keyser,	, WV
any	-	Oa. State 10b. County 10c. City, Town or Location				1	ide City Limits
Aaryland 28a-f show 1 at once.		WV Mineral Burlington					es 2 X No
the Maryland as a or 28a-f sh tiffed at once	11	0e. Street and Number 10f. Zip Code		10g. C	Citizen of What	Country?	
tith the Maryland 23a or 28a-f sho notified at once		Rt. 1, Box 152–F Shirley Lane 26710  1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Ves	or No-	USA	American India	n Black
r death with or items 23 cmust be no	1,	Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	to Rican, etc	c.)	White, 6		, 2.22.,
fter de		1 Yes 2 No  No specify:			Specify:	White	
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5-0036 ed within 72 hour hygiene. other than "natu the Medical Exar Completed	-	12 Sawyer/Laborer  7. Father's Name (First, Middle, Last) 18.Mother's Nam	ne (First, Mi	ddle, Maid		aw Mill	
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2121 hould be fil and Mental I is marked rite event,		9a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	r Rural Rou	te Number	, City or Town,	State, Zip Coo	de)
MD and 2 sho alth and m 27 is aumati		Merle Sue Duncan/Sister 294 Fountainhead Dri	ive F	Keyse	c. Location - C	26726 Sity or Town, S	tate
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I file it is 7 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	ct. 8				
Baltimore, permit. Pages I ar Department of Hee Important: If ite	L	4 Donation 5 Other Specify: Knotts Family Cemetery	2009		Burling	-	V
Baltimore, Mi permit Pages I and 2 so Department of Health a Important: If iten 27 injury or other traum	2	21. Signature of Funeral Service License Rt. 2, Box 1-A			al Home	e 26710	
Physician	12	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respirat	ory arrest,	shock, or hear	t Appro	een Onset and
/Medical	١.	failure. List only one cause on each line. Mixed drug (Meperidine, Oxazepam Immediate Cause (Final disease a. complicating metastatic lung carci	n, Chl inoma	ordia	azepoxı	de)	Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):					
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68760, certificate be nding physici use as the buri		F FEMALE: 23c. If yes, outcome of pregnancy	<u> </u>		23d. Date of d		
6876 certificat iding physe as the	2	3b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	gnancy		Month	Day	Year
30x 6876 death certificate e attending phy	200	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)		_			
Records, P.O. Box The law requires that the death icate has been signed by the atte page 2 should be detached for u		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236		cco use contrib		,
ires that signed I be deta	in Di		- 1	Yes		Probably 4	
Records, The law require. ficate has been significate has been significantly by the second by the se			_   248	a. Was an autopsy performe	pr	rere autopsy m rior to completi eath?	ndings available from of cause of
Reco	5		1 🗸	Yes 2		<b>✓</b> Yes	2 No
ian:		25. Was case referred to medical examiner? Hospital: 1 Incation: 2 FR/Outpatient 3 DOA Other Nur.				70%	
Physic r this or al dire	٥ [	1 V Yes 2 No	rsing Home	escribe hov	sidence 6 v injury occurre	Other:	
Division of Vital Records, P.O. Box 6876 rat or Attending Physician: The law requires that the death certificat and safer death.  all Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the attending to the director of the property of the province of the provinc		1 Natural 5 Pending Panding Pa	subj	ect ( icati	given n	ot pre	scribed
ivisior  Tor Attend after death. Director:		2 X Accident Investigation   Fd 10/2/09   Fd 2110   T10   28e. Place of Injury - At home, farm, street, factory, office building, etc.				r or Rural Rou	ite Number, City
Div ital or ral Div	Certification:	3 Suicide 6 Could not be determined (Specify) other	Hea.	Town, Stat Ith S	ystem I	Braddoc	ite Number, City 'land 'k Campus
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To the within To the comple	s L	(Check only one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the tin		29d. Date signe		
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.			October 4,	•	,,,
		30. Name and address of person who completed cause of death (Item 23a)					
		30. Name and address of person who completed cause of death (term 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201				
Sta	te	31. Date filled (Month, Day, Year) 32. Registrar's Signature					
Registra		OCT 1 5 2009 Jenna A. Sarles				MOO.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lilja Joanne Μ. Physician/ Sept. 26 Day 2009 Year 5:25a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death .. County of Death Montgomery **Examiner** Potomac Manor Care Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 027-14-6472 1 □ M 2**X** F Months 2MP0/9P1/1/9/25 Boston, MA. 84 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director MD Montgomery Rockville 1 ☐ Yes 2 🛂 No #406 10f. Zip Code 10g. Citizen of What Country? 14431 Traville Garden Circle Funeral USA 20850 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or ģ ☐ Yes 2 🔀 No Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. If Yes, Give Specify: Completed 3 X Widowed 4 Divorced Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joann Caliri A.Frank Garbarino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5509 Kirkwood Drive Bethesda, Md. 20816 19a. Informant's Name/Relationship (Type, Print) Geoffrey Lilja/Son other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite 1 Burial 2 K Cremation 3 Removal from State Chesapeake Crem. 9/28/2009 Beltsville, Md 4 Donation 5 Other (Specify) injury 21. Sign tu of Faneral Service PHYMERAL SERVICE, P.A. any 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death 5min. Immediate Cause (Final Myocardial infarction Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** months Sick sinus syndrome Sequentially list conditions. Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury months Aortic stenosis To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Box ( in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death the a P.0. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pulmonary edema, diabetes Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown been significant beautiful to the should be sh Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has t page 2 s autopsy performe certificate | 1 Yes 2 No Yes 2X No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check

29b. Signature

only one

31. Date filed (Month, Day, Year)

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Date signed (Month, Day, Year)

M1)20878

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Ce	ertificate of Death	Reg	ene g.No.2009	0005)
П	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
-4	/Medio Examir		Dorothy A. Lee  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	September	26,2009 4c. County of Death	7:20 P M
j P	LAAIIII	IGI	Rexford Place	Lanham		Prince Geo	rge's
E	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	// If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign
	Director		245-30-5688 1□M 2\(\frac{1}{M}\)F 86 Yrs.	monute Baye Hours Willi.	SEPT. 27	,1922 ALA	BAMA
	rland ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation	<u> </u>	1	0d. Inside City Limits
	Mary a-f sh	tor	MD. PRINCE GEORGES	BOWIE			Y∏Yes 2 No
	th the	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	ntry?
	ath wi	ra	4401 HOLMEHURST WAY	20720		U.S.A.	
	er dez items	Funeral (	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland that Hyglene.  ad other than "natural", or items 23a or 28a-f show event, i're Medical Everyinar must be nothed at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ₹ No If Yes, Give X 3 ▼ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 21 No Specify:		Specify:	1 CT
215-0036	2 hou latura ical E	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	BL Sb. Kind of Business/In	ACK dustry
21	thin 7 ne. ian "r	Completed	(Specify only highest grade completed) (Given life.  Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worki DO NOT use retired)	ng		
21	ed wi lygier her th		<u>5</u> +	TEACHER		PUBLIC S	CHOOL
anc	l be fii intal H ed ot	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		· ·	
Maryland	should and Mer is marke aumatic	ည	DAVID JACKSON  19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ling Address (Street and Number or Rura	AGGIE	CHESSER	Cada)
	1 and 2 s Health ar sem 27 is			1 HOLMEHURST WAY, I			Code)
ore,	es 1 a of Her litem		20a. Method of Disposition 20b. Place of Disposition			Oc. Location - City or To	own, State
<u>Ĕ</u>	Pages ment of ant: If ite ury or o		Denial 2 Cremation 3 Chemova from State	NCOLN CEM. 9-30-	-2009	BRENTWOOD,	MD.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Experiment must be notified at once.	ſ	21. Signature of Funeral Service Licensee	22. Name and Address of Facility CHAMBERS FUNERAL HO 5801 CLEVELAND AVE			
			23a. Part1. Enter the disease, or complicating that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	ALE, MD. <u>Z</u>	Approximate
MEG.	Physician			dementia			Interval Between Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence ?):	- qonann			1 years
	LXammer	7	Sequentially list conditions, b.				
,	uted I nsit	Examiner	Sequentially list conditions, it may be said to the following cause. Enter Underlying Cause (Disease or injury that initiated events  c.				
Ċ.	exection and and ital-tra	Еха	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
68760,	rtificate be executed ng physician and as the burial-transit	edical	d				
			IF FEMALE:				
Вох	death cer e attendin d for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of deliver	ery Day Year
	the de	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		World	Day Tour
ت. ت.	w requires that the dispension of the should be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
Records,	quires an sign uld be	ed by			1 ☐ Yes	2 □ No 3 □ Prot	pably 4 Unknown
၀၁	law re as bec 2 sho	pleted			24a. Was an	24b. Were auto	psy findings available
	The	Compl			autopsy performe 1 □ Yes 2 [	d?/ death?	mpletion of cause of
Vital	iding Physician: The th. After this certificate funeral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death		ASSISTED I	IVING FACILITY
5	Phys this al dir	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manger of Death 28a. Date of Injury 28b. Time of		ne 5 Residenc		
0	ding th. : Afte fune	ţi	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
DIVISION	Attence or death ector: by the	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	_		et and Number or Rura	al Route Number,
ַ בֿ	tal or	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	0.0
	To the Hospital or Attending Within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, dea 2  Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau ed at the time, date	use(s) and manner as s e and place, and due to	stated. the cause(s)
:	Compt to	ğ	29b. Signature and title of certifier.	29c. License number		I. Date signed (Month,	Day, Year)
	5		► Gay Kiffinan, MO	025001		9-28-09	
			30. Name and address of person who completed cause of death (Item 23a) (Type, TAY LIPPMAN MO 705 DIG	Print) OR STEG	LINT	HICUM MA	21090
	Stat Registra		31. Date filed (Month, Day, Year) SEP 3 0 2009  32. Registrar's Signature	N.S			

			1 - State of Maryland State of Maryland Registrar		tificate of I			eg. No.	9 55060
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death
	/Media	cal	Joan Elaine Stine Long				SEPTEMB1	ER 25 200	
À	Examir	er	4a. Facility Name (If not institution, give street and number) 1125 Martha's Court		Knoxvi1	Location of Death		4c. County of Freden	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day)	Voar) 9	Birthplace (State or Foreign Country)
alfred a	Director		220–28–7713 <sup>1 M 2X F</sup> 75	Yrs.	Months Days	Hours Min.	AUG 24	1934 B	runswick, MD
	land ow tt		Usual Residence of Decedent  10a. State 10b. County 10c. City, 7	Town or Loc	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD Frederick Kno	xvil1	.e				1 □Yes 2X No
	ith the or 284	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wha	at Country?
	sath w s 23a nust t		1125 Martha's Court	1.0.0	2175			USA	A
	tter de r Item iner n	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ▼ Married  1 □ Yes 2 ▼ No	I		ispanic Origin? (Spe an, Mexican, Puerto	ecity Yes or No- Rican, etc.)		American Indian, White, etc.
036	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notifiled at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	□Yes 2ÅNo	Specify:		Specify:	White
21215-0036	be filed within 72 hours after death with the Marylar ntal Hygiene. et other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occup	ation during most of worki	na	16b. Kind of Busin	,
121	within 72 ene. than "na' he Medic	mp	Elementary/Secondary (0-12) College (1-4or 5+)			, inistrato		Maryiand Depart	State Health
d 2	e filed value of the state of t	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name			
/lan	2 should be and Mental is marked of aumatic ever	To B	William Ernest Stine			Dorothy	Agnes Do	onovan	
Maryland	2 should and Men is marker raumatic					and Number or Rura			ate, Zip Code)
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic				Martha's	Court, K			1758
nor	ages int of l t: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cerr	netery, crem	natory or other plac	ee)		20c. Location - Cit	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		4 Dongton 5 Other (Specify) Zion 21. Signate September 2 Augustian Fundamental September 2 Augustian September	22	Name and Addres	netery 9/2		Middleto	wn, MD
ä	permi Depa Impo any ir		Barbara A. Williams, Owner	1	ohn T. W 00 Peter:	illiams F sville Ro	uneral I ad, Bru	Home nswick, N	1D 21716
A.			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.				or respiratory arre	est,	Approximate Interval Between Onset and Death
ī,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		1 intar	chis			Onset and Death
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	7. I	ner	Sequentially list conditions, it is a local to the local and the local a	nce of):					
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent or consequent o						
,00	ificate be executed g physician and as the burial-transit	a E	Due to (or as a consequer	ice oi):					
68760,	E 170 m	edical	d.						
Box		an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal de		Ectopic pregnancy			23d. Date o	
0	The law requires that the death cer te has been signed by the attendin page 2 should be detached for use	Physician/N	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  9 □ Unknown		Other (specify)			Month	Day Year
P.O.	that the ed by detac	h)	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did tob	pacco use contribu	ite to the cause of death?
Records,	w requires that the d been signed by the should be detached	d by					1 □ Ye	es 22 No 3[	☐ Probably 4 ☐ Unknown
ဝ၁	law re	Completed					24a. Was a		re autopsy findings available
Œ =		Com					autops perforr 1 Yes 2	ned2, dea	r to completion of cause of th? Yes 2□ No
Vital	ician: sertific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Othe	26. Place of Death	Check onl on	е	
0	ding Phys h. After this funeral dir	2	1 Inpatient 2 EH	NOutpatient  Bb. Time of		4 LI Nursing nor		ence 6 Other (	(Specify)
ion	Attending r death. ector: After by the fune	atlor	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injury Work M 1 🗆 `	k? Yes 2 □ No			
Division or	or Attendate death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	2	28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,
Ω	pital o		200 Continue de Continue Develoire To the heat of an Institute					()	
	To the Hospital or Attending Pr Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowle 2 ☐ Medical Examiner: On the basis of examination and manner stated.	oge, death n and/or inv	estigation, in my o	ne, date and place, a pinion, death occurr	and due to the cared at the time, d	ause(s) and manno ate and place, and	er as stated. I due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	_	29c. License	number	2	9d. Date signed (A	Month, Day, Year)
			), UUU My	1	031	178		9-28	-09
	10		30. Name and address of person who completed cause of death) (Item 23	3a) (Type, F	Print)	, Mol.	21-	. /	
	Sta	te	31. Date filed (Month, Day, Year) 32. Regintar's Signatur	hsu	VICE	, red.	2171	6	
	Registr		SEP 2 9 2009 Xeneur	A. 1	backer				

		•	1 - State of Mary		artment of F rtificate of L	ieaith and Mer Death	ntai Hygier Reg. i	, 111	33061	
	Physici	an	Decedent's Name (First, Middle, Last)  Elva Mae	Lewis			Date of Death Month	Ž4, 2009	3. Time of Death 4:10 p. M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	DCW13		Location of Death		4c. County of Death		
	Funeral			In yrs. last birthday)	Middleto If Under 1 Year	If Under 24 Hrs To	Date of Birth (Month, Day, Yea	Frederi	Place (State or Foreign ntry)	
	Director		212-38-9388 1 □ M 2 🛣 F Usual Residence of Decedent	85 Yrs.	Months Days	Hours Min. J	uly 18,	1924 Mar	yland	
	death with the Maryland rms 23a or 28a-f show r.rwst be rodified at	ctor		Oc. City, Town or Loc					10d. Inside City Limits X☐Yes 2☐No	
	th with the 23a or 28 ust be no	ral Dire	10e. Street and Number 324 East Patrick		10f. Zip Code <b>217</b> 0	)1		Citizen of What Cou ISA	ntry?	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be redified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cuba I□Yes 2☐Mo	ispanic Origin? (Specify n, Mexican, Puerto Rica Specify:	/ Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify:		
Maryland 21215-0036	nin 72 h 9. In "natu Medical	plete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	dent's Usual Occup kind of work done o OO NOT use retired	durina most of workina	16b.	16b. Kind of Business/Industry		
121	lled witl Hygiene ther the nt, Ire	Com	8  17. Father's Name (First, Middle, Last)	Home	maker	18. Mother's Name (Fi		Own home		
/lan	uld be f Mental arked o	To Be	Walter Fogle			Mary Fi				
	nd 2 sho alth and 27 is me r trauma		19a. Informant's Name/Relationship (Type. Print)  Betty Jane Bussard - daughte			er Road, M				
Baltimore,	. Pages 1 au tment of Hea tant: If Item jury or othe		A Burial 2 Li Clemation 3 Li Removar from State	20b. Place of Dispos cemetery, crent Garfield Church Cen	United Ma	thodict'	2009 Sm	Location - City or T	own, State  Maryland	
Ball	permit Depart Import any in		21. Signature of Funeral Service Ricensee	Church Cer		<sup>ss of Facility</sup> Stau umtown Pike		neral Home rick, Mary		
40			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	e death. Do not ente	er the mode of dyin	ig, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a condition)	onsequence of):	दयहा न	4.10FC			5 %	
	Examiner	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a c	onsequence of):						
	ecuted and transit	camin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
68760,	ate be ex nysician he burial	edical Examiner	resulting in death) Last  Due to (or as a c	onsequence or).						
	certifica nding pl		IF FEMALE: 23c. If yes, outcome of	pregnancy				23d. Date of deliv	JOTY.	
P.O. Box	t the death by the atter ached for u	Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)	у		Month	Day Year	
	iires tha signed d be det		Part II. Other significant conditions contributing to death but n	ot resulting in the un	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?	
Records,	aw requas been 2 should	Completed by	H3F				24a. Was an	-	opsy findings available ompletion of cause of	
al R	n: The licate har, page						autopsy performed 1 □ Yes 2 ☑	death? No 1 □ Yes	2 No	
f Vit	nysiciai iis certi directo	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	26. Place of Death (C er: 4 ☐ Nursing Home		e 6X Other (Spec	Daughter's	
o uo	ding Ph h. After th funeral	tion: 1	27. Manuer of Death  1 Natural 5 Pending (Month, Day, Y	(ear) 28b. Time of Injury	Work	yat 28d k? Yes 2 □No	. Describe how in	njury occurred	TIONIC .	
Division of Vital	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate bas been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	2 Cuiside 6 Could not be	- At home, farm, stre (Specify)			Location (Street City or Town, St	t and Number or Rui ate)	ral Route Number,	
	To the Hospita within 24 hours To the Funeral completely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician; To the best of read the control of the basis of evand manner stated	xamination and/or inv	n occurred at the tirvestigation, in my o	me, date and place, and pinion, death occurred	I due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
	To th within To the	Me	29b. Signature and title of certifier		29c. Licens	e number	29d.	Date signed (Month	, Day, Year)	
	1		30. Name and address of person who completed cause of deat	th (Item 23a) (Type 1		~17]		1/25/25		
	1		30. Name and address of person who completed cause of deat	word (N)	7					
	Sta Registr		31. Date filed (Month, Day, Year)  SEP 2 9 2009  Serve	signature A. A.	parke					

09-0	7691		Please Type or Print in Black Indelible Ink. Ensure All Cop	oies Are Le	gible.		
Bev	erly Jean La		State of Maryland / Department of Health and Mental Certificate of Death		eg. No. 200	9 3306	
	Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Dea	th	3. Time of Death	
Me	Filysicia dical Exami		BEVERLY JEAN LANCASTER	Month October 3		0315 hrs	
			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of D	eath	4c. County of Death Prince George	c	
			Prince Georges Hospital Center Cheverly	u. la pur «(pi	th(MM/DD/YYYY) 9. Birth		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	Min.	Foreign	Cheverly	
	Director		578-84-1109 1 M 2 XF 50 Yrs. 50	11/28	/1958 L	MD	
	ķ	- [	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	ow any		77 17 4.0			1 X Yes 2 No	
	ryland a-f sh f once	횽	DC Washington  10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?		
	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	1301 7Th Street NW # 203 20001		United Stat	es	
()	vith the s 23a e noti	<u></u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No	14. Race - Americ White, etc.	can Indian, Black,	
15079	leath y	Funeral	1 Never Married 2 Married 2 Armed Forces? 1 Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)			
0	after d al", or	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: B1a		
5	ours and a sami	be be	15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kin during most of working life. DO NOT us	d of work done e retired)	166. Kind of Business/i	ndustry	
1	16 n 72 h nan "r ieal E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  1 1 Home Improvement		Private		
	5-0036 led within 7 Hygiene. lother than	E O		Name (First, Middle,			
	filed at Hyger of	Be C	Cliffinal C. Languatar	nice Youn	σ		
	2121: buld be fil   Mental B   marked ic event,	To E	Clifford G. Lancaster  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number and Number 2014)	er or Rural Route Nu	imber, City or Town, State	, Zip Code)	
	MD d 2 sho lith and m 27 is	П	Bernice R. Foster / Sister 1301 7th Street NW	# 203 Wa	shington, Do	7_20001	
	e, F I and Healt Fitem		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City or	Town, State	
	altimore, mit. Pages I ar partment of He portant: If ite jury or other tr		Harmony Memorial	0/10/2009	Landover.	Maryland	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Si Anature of Funeral Service Li e see 22. Name and Address of Facility	lexander	S. Pope Fund	eral Home	
	W FYE		23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as care	a Ave. SE	Washington rrest, shock, or heart	DC 20020 Approximate Interval	
	Physician dical		failure. List only one cause on each line.			Between Onset and Death	
1	xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				
			b				
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.				
		Examiner	C.  (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
	ansit		u.				
	executan an	<u>[</u>	X UNPENDED	3/09 TT			
	tox 68760, eath certificate be execut attending physician and for use as the burial - tra	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive Month	ry Day Year	
	687 ertific ding p	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	pregnancy	Monu	Day Teal	
	Box 68760, e death certificate be the attending physic ed for use as the bur	sic	1 Yes 2 No 9 V Unknown	-m-			
	D. E t the d by the ached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par		tobacco use contribute t		
	P.( es tha igned be det	o F		_		obably 4 Unknown	
	rds, requir been s	Completed			topsy prior to	autopsy findings available completion of cause of	
	e law	<u>E</u>			rformed? death?		
	Re n: Th tificat	ြပ္သ		Check only one)			
	n of Vital Records, P.O. Bing Physician: The law requires that the de After this certificate has been signed by the fineral director, page 2 should be detached it	Be Be	examiner?  Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA  Other 4	Nursing Home 5	Residence 6 Oth	er:	
	of \ ug Ph; filter the		27 Manner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury at Work?	I .	be how injury occurred		
	On tendiir sath. or: A	5	1 Natural 5 Pending Investigation 10/3/09 2:21 am 1 Yes 2 X			Number City	
	Division of Vital Records, P.O. optial or Attending Physician: The law requires that the ours after death.  The law seem signed by the certificate has been signed by filled in by the finered director. After this certificate by should be death.		2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) Friend's House	28f. Location	n (Street and Number or I n, State 5 1 2 7 Due Ont: Heights	1 P1 •	
	<u>1</u> 0 0 0	Certification:	4 Homicide determined (Specify) Friend's House				
	To the Hos within 24 hos connected to	edical (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ	ce, and due to the c curred at the time, d	ause(s) and manner as st ate and place, and due to	the cause(s)	
		edi	and manner stated.		29d. Date signed (A		

29b. Signature and title of certifier Theodore M. King, Jr., MD.

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 4, 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of Ma	aryiariu /	•	rtificate of	Health and N Death		Reg. No.	U			
			Decedent's Name (First, M	ddle, Las	st)					2. Date of Dea	ath Day	Year	3. Time of Death		
	Physicia /Medic		James Arthu	r Le	ysath					Septem		28,2009	2:20 A. M		
	Examin		4a. Facility Name (If not institu					4b. City, Town,	or Location of Death		4c. County of Death				
4			Gladys Spel 5. Social Security Number	lman	Nursing H	iome e (In yrs. last	hirthday)	Cheve If Under 1 Yea		8. Date of Birth 9. Birthplace (State					
ı	Funeral Director		578-68-2413	1	M 2□ F 59		Yrs. Months Days Hours Min. (Mo. 05)					Date of Birth (Month, Day, Year) 5/09/1950  9. Birthplace (State or Foreign Country)  Swansea, S.C.			
	and ow f	1	Usual Residence of Decedent  10a. State 10b. Cou			10c. City, To	own or La	cation					10d. Inside City Limits		
	Mary -f sho	to	Md. F	.G.		(	Capit	ol Heigh	nts				Y☐Yes 2☐No		
	h the	Director	10e. Street and Number					10f. Zip Code			10g. Citiz	zen of What Cou			
	th wil		6308 K Stre	et					0743			U.S.A.			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exp. direct must be nothed at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Divor  3 □ Widowed 4 □ Divor		12. Was Decedent B Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:		71	Was Decedent of If Yes, specify Cu 1 □Yes 2√N	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify:			
15-00	"natura "natura edical E	Completed	15. Dece (Specify only hi	ghest gra	ide completed)		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of work	king	16b. Kir	nd of Business/Ir	ndustry		
712	withii jene. r than	шо	Elementary/Secondary (0-1	2)	College (1-4or 5	i+)		hef				Culinar	<b>-</b> y		
פַ	filed al Hyg other	Be C	17. Father's Name (First, Mid	die, Last,	1				18. Mother's Nam	e (First, Middle	, Maiden	Surname)			
<u>lar</u>	uld be Mentz Irked	일	David Leys	ath						ce Mims					
lar)	2 sho and is ma		19a. Informant's Name/Relat						et and Number or Ru						
e)	l and lealth		Pamela Leysa 20a. Method of Disposition	tn/w	lie	20h Plac			reet,Capit	Date Date		cation - City or T			
Baltimore, Maryland 21215-0036	Pages ment of I		1 ★ Burial 2 Cremat 4 Donation 5 Othe				yland		ns Cem. 10				, Md.		
Balt	permit Depart Import any Inj once.		21. Signature of Funeral Ser	vice Lice	Cray		2	2. Name and Add H.S.W 4925 Bur	ress of Facility ashington roughs Ave	& Sons	Co., Wash	Inc. ington.	D.C.20019		
	·		23a. Part 1. Enter the diseas shock, or heart failure.	e, or com	plications that caused one cause on each lir	the death. I	Do not en	ter the mode of o	ying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death		
· de	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a. Multisy			ıre					months		
	Examiner		_	- 1	Due to (or as			Infarct	ion			4	months		
		ner	Sequentially list conditions, if any, leading to immediate	J	Due to (or as	a consequer	nce of):								
	ecuter ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c. Diffuse			Atheros	clerosis_				years		
68760,	ificate be executed g physician and as the burial-transi	al E	resulting in dodain, East	l	Due to (or as	a consequer	ice or).								
687	ificate g phys	edical			d										
P.O. Box	eath cert attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal de	eath 3	☐ Ectopic pregna☐ Other (specify,				23d. Date of deli Month	ivery Day Year		
	v requires that the d been signed by the should be detached	₽ P	Part II. Other significant con		_				given in Part I.				the cause of death?		
Š	requi	eted	Diabetes Me	-						24a. Was	an	24b. Were au	topsy findings available		
II Re(	The law cate has page 2 (	Completed	Parosysmal '							auto	psy ormęd?	prior to death?	completion of cause of 2 □ No		
Vita	iclan: certifi ector,	æ	25. Was case referred to me examiner?	dical	Hospital:				26. Place of Dea			• Flore - 10			
of	Phys ral dir	5	1 Yes 2 No 27. Manner of Death		28a. Date of Inju	ury 2	8b. Time	of 28c. Ir	njury at	lome 5 ☐ Res 28d. Describe		6 ☐ Other (Spectry occurred	city)		
o	th. : Afte	tion	1 Natural 5 ☐ Pe	ending restigation	(Month, Da	ay, Year)	Injury		√ork? □Yes 2□No						
Division of Vital Records,	or Attending Physician: after death. Director: After this certific. I in by the funeral director, I	Certification: To	3 ☐ Suicide 6 ☐ C	ould not be termined	28e. Place of Injuding, et	jury - At homi tc. <i>(Specify)</i>	e, farm, si	treet, factory, offic	ce	28f. Location City or To	(Street ar wn, State	nd Number or Ru e)	ural Route Number,		
_	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 > Cer (Check only 2   Medone)	tifying P lical Exa	hysician: To the best miner: On the basis of and manner st	of examinatio	edge, dea n and/or i	ath occurred at th investigation, in n	e time, date and plac ny opinion, death occi	e, and due to th urred at the time	e cause(s e, date an	s) and manner as d place, and due	s stated. e to the cause(s)		
	To the I within 2 To the I complet	Mec	29b. Signature and title of ce	rtifjer				29c. Lic	ense number		29d. Da	ate signed (Monta	h, Day, Year)		
	->-0		<b>•</b>	611	Juntagi	mo		I D	24720		Septe	ember 28	,2009		
	, 3+1		30. Name and address of pe												
1			Ravinder K.  31. Date filed (Month, Day,		agi, M.D. 6	132 La	ndov	er Road,	Cheverly,	Marylan	nd 2	0785			
	Sta Regist		OCT 0 1 2009		32. Regist	far	Car.								

		-	For State Registrar	State of Marylar		ertificate of			giene Reg. No.	
			Hegistrar     Decedent's Name (First, Middle,	l act)				2. Date of Dea		3. Time of Death
	Physicia	an	YVONNE	BELL	LASSI'	TED		Month SEPTEMI	Day Year BER 27 2009	9:45 P M
	/Medic	al			LASSI		r Location of Death	SEFIEM	4c. County of Death	
	Examin	er	4a. Facility Name (If not institution,			CHEVI			PRINCE G	
/			PRINCE GEORGE'S		la at hirthday			8. Date of Birtl		pplace (State or Foreign
	Funeral Director		178-34-9619	Sex 7. Age (In yrs	Yrs.	Months Days	Hours Min.	(Month, Day	y, Year) Con	NSYLVANIA
5	>		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or L	ocation				10d. Inside City Limits
arvla	show	_	,							1 XYes 2 No
Ž.	28a-f	ctc		GEORGE'S	UPPE	R MARLBORO	0		10g. Citizen of What Co	intn/2
ŧ	or 2	Funeral Director	10e. Street and Number			10f. Zip Code			3	arto y .
th v	23a ust t	<u>ra</u>	400 KETTERING C			20774		7 7 7 1	USA	i Indian
ă	ems	l ne	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S.   13	. Was Decedent of H If Yes, specify Cuba	tispanic Origin? (Sp an, Mexican, Puerto	ecity yes or No- Rican, etc.)	14. Race - Ame Black, White	
2 4	P		1 Never Married 2 Marrie	I If Yes. Give		1∐Yes 2 <b>X</b> ∏No	Specify:		Specify: B	LACK
	le al	d by	3 Widowed 4 Divorced	Year or Dates:	11110				16b. Kind of Business/	ndustry
2 5	"natural", or items	Completed	15. Decedent's (Specify only highest	Education grade completed)	1 (Giv	edent's Usual Occup le kind of work done . DO NOT use retire	during most of work	ring	100. Killa of Busilless/	ridusti y
بَ نِهِ	Fan .e	ďω	Elementary/Secondary (0-12)	College (1-4or 5+)			•		DD T77A T	E
ک ا	lygie nt, in			1 YR	PK	OPERTY SP		o (First Middle	PRIVAT  Maiden Surname)	Е
he filed within 72 hours after death with the Maryland	Mental Hygiene.	Be	17. Father's Name (First, Middle, La WILLIAM BELL	ist)			ANNABE		ORDAN	
should	Should be manual to manual	မ			1					Zia Cada)
	Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Exercitment to rediffed at		19a. Informant's Name/Relationshi	o (Type. Print)	19b. Mai	iling Address (Street	and Number or Hu	rai Houte Numbe	er, City or Town, State, 2	up Code)
, and	Health item 27 li	5 8	EDMUND LASSITER	SR./HUSBAND				PPER MAI	RLBORO, MARY 20c. Location - City or	
Pages 1	If ite		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3	Removal from State	cemetery, cr	position (Name of rematory or other place	ce)		,	
	теп ant: ury		4 ☐ Donation 5 ☐ Other (Spe			RANS CEME			CHELTENHAM	·
	Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Li	censee		22. Name and Addre			ENKINS FUNE	
	20 5 20		CH R						OVER, MARYLA	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omplications that caused the dea nly one cause on each line.	ath. Do not e	enter the mode of dyl	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
P	hysician		Immediate Cause (Final disease or condition	FATAL CA	RDTAC	ARRYTHMIA				Oriset and Death
	/Medical		resulting in death)	Due to (or as a conse	equence of):					
E	xaminer		Conventially list conditions	DIABETES		US				
	· =	ner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying	Due to (or as a conse	cuenne offi					
d d	ind trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. <u>HYPERTEN</u>						
Of VII at he low requires that the death cartificate he executed	hysician and the burial-transit	m	resulting in death) Last	Due to (or as a conse	equence of):					
o de de	hysic he bi	ical		d						
اِ اِ	attending physic	Physician/Med	IF FEMALE:		37.5					
אַ קַּ מַ	tendi r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome of preg		3 ☐ Ectopic pregnan	су		23d. Date of de Month	livery Day Year
, de	he at	sici	in the past 12 months? 1 ☐ Yes 2 🔀 No	4 ☐ Pregnant at time o 9 ☐ Unknown	f death 5	5 ☐ Other (specify) _				
7 t	d by t	hy	9 Unknown			da ali da a a a con a ab	una in Don't	23a Did t	obacco use contribute to	the cause of death?
ָּהָ מָי	igner be de	þ	Part II. Other significant condition	is contributing to death but not re	esulang in trie	dridenying cause gr	ven in Fait i.		Yes 2 □ No 3 □ P	
cords,	sen s ould								res 2 140 0 ;	- ZEJ OHIGIOWI
	as be	ble						24a. Was autor	psy prior to	utopsy findings available completion of cause of
ב ב	ate h	Completed						perfo 1 ☐ Yes	ormed? death? 2 ☑No 1 ☐ Yes	s 2 <mark>X</mark> □No
	n, After this certificate has been signed by the funeral director, page 2 should be detached	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only o	one)	
<b>&gt;</b>	uis ce direc	TO E	examiner? 1	Hospital: 1 ☐ Inpatient 2	X ER/Outpat	tient 3 DOA Oti	her: 4 □ Nursing H	lome 5 ☐ Resi	dence 6 ☐ Other (Spe	ecify)
_ 7	<b>9</b> 0 0	Ë	27. Manner of Death 1 ☐Ñatural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time Injur		ıry at rk?	28d. Describe	how injury occurred	
VISION	ath. r: Af	atic	2 ☐ Accident investiga	ation			]Yes 2 □No			
S {	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		home, farm, cify)	street, factory, office		28f. Location ( City or To:	Street and Number or R wn, State)	ural Route Number,
5 5	rs aft al Di	Ç								
Hoen!	within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier 1 A Certifying (Check only one) 2 Medical E	p Physician: To the best of my k examiner: On the basis of exami and manner stated.	nowledge, de ination and/or	eath occurred at the trinvestigation, in my	time, date and place opinion, death occi	e, and due to the urred at the time,	, date and place, and du	e to the cause(s)
Ę	Voith Com	Ž	29b. Signature and title of certifier				se number	0	29d. Date signed (Mon	ın, ∪ay, Year)
			1 Moly	1200		U	6368	0	9/30/09	
./	,5		30. Name and address of person v				TT 1 *		20010	
NL			Griffin Davis	M,D. 110 Irv	ing St	reet N. W	. Washing	ton, DC	20010	

State Registrar ffled (Month, Day, Year)

32. Registrar's Signature.

			For State Registrar	S	tate of M	larylan	_		nt of H te of D	lealth and Death	Mental Hy	gien/ Reg. N			0
	Physicia		1. Decedent's Name (First, Middle  Marie	e, Last)	E. Lu	shv					2. Date of De Month Sept		2009 Yea	,	3. Time of Death 1:35 P M
	Medic Examir		4a. Facility Name (if not institution	, give street		БОУ		4b. Cit	y, Town, or	Location of Deat			Ic. County of De	ath	1:33 P ···
_			Corsica H	i11s		Centerville						Queen Annes			
	Funeral Director		5. Social Security Number 024 16 4118	6. Sex 1		e (In yrs. I 87	ast birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Day May 21	rth ay, Year 19	) (	Birthplac Cou <i>ntry</i> ,	ce (State or Foreign )
	ind show	5	Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or Lo	cation						10d	I. Inside City Limits
	Maryla Ba-f s	Director	Maryland Queen	n Anne	<u>;</u>		CEN	TERV	ILLE						1 🗆 Yes 2 📆 No
	a or 2	Ö	10e. Street and Number	Number 10f. Zip Code 10g. 0								Citizen of What Country?			
	ns 23	Funeral	215 ARMSTRONG AVE P.O. BOX 50 21617 United S									ited St	ate	S	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Widowed 4 □ Divorced	ried 1	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates.			<ul> <li>13. Was Decedent of Hispanic Origin?         If Yes, specify Cuban, Mexican, Pt     </li> <li>1 ☐ Yes 2 ☐ Who Specify:</li> </ul>			pecify Yes or No o Rican, etc.)	-	14. Race - Ar Black, Wh Specify:		
5	hours natur Jical B	olete	15. Decede	nt's Education	on	-	16a. Decec	lent's Us	ual Occupa	tion		16b.	Kind of Busines	s Indus	
21218	within 72 giene. er than " the Mec	Completed	(Specify only higher Elementary/Seconday (0-12)		mpleted) ollege (1-4 or t	5+)	life. Do	kind of w O NOT u C <b>ret</b> 8	se retired)	uring most of wo	rking				vernment
Maryland 21215-0036	d be filed valental Hygurked other irked other tic event,	To Be	17. Father's Name (First, Middle, I James H. )		:11					18. Mother's Nar	ne (First, Middle rances ]		,		
lan	2 should be the and Me 27 is mark		19a. Informant's Name/Relations		,		1	-		nd Number or Ru				,	,
	and 2 s Health tem 27		Patricia Barth 20a. Method of Disposition	n (Nie	ce)	1.00				oa Road,	Joppa,				
nor	Page 1 annument of the ant: If its ury or of		1XXBurial 2 ☐ Cremation	3 🗆 Remo	val from State			natory or	other place	) Oct 1,	2009		Location - City		
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (S		/	<u> Re</u>	surrec	Lior Name a	Ceme	eteriy	P 1		linton,		
ñ	permi Depar Impor any ir		Mario Tel	hein		257	A1	exar	<u>idria</u>	s of Facilit <b>L</b> ee Ferry R	oad, Cli	into	me, Inc n, MD	66. 207.	
7	Pnysician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complication only one cau	ns that caused se on each line	d the death	A 1		de of dying	•	or respiratory a	rrest,	عو	In	pproximate Iterval Between Inset and Death
	Medical Examiner		resulting in death)	<b>~</b>	Due to (or as	a consequ	ience of):								
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. —	Due to (or as	a consequ	uence of):								
	icate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last	c. —	Due to (or as	a consequ	uence of):								
760	cate b physi	edical		d											
Box 68	ath certif attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 poorths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	yes, outcome Live Birth Pregnant a Unknown	2 Feta	i death 3	Ectopic Other (s	pregnancy		78		23d. Date of o	lelivery Da	ay Year
P.0.	requires that the de been signed by the s should be detached	þ	Part II. Other significant condition	ns contribu	ting to death b	ut not res	ulting in the u	nderlying	cause give	en in Part I.			use contribute		
ords	require been si should	leted									1		-		findings available
Records,	sician: The law certificate has rector, page 2 s	Completed	25. Was case referred to medical	-1									prior to	comp	letion of cause of
Vita	/sician: s certific director,	To Be	examiner?	Hospita	al:	ont 2	ER/Outpatien	+ a $\Box$ r	Other	ce of Death (Chec			C	- 16.0	
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate: T	27. Manner of Death  Platural 5 Pendin 2 Accident Investig	g	la. Date of inju (Month, Day	ry	28b. Time of injury		28c. Injury : work?	at	ome 5 Resi			есіту)	
DIVISI	tal or Atters after de al Directo ed in by the		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		e. Place of Inju building, etc			et, facto	ry, office		28f. Location ( City or Tov		nd Number or R e)	ural Ro	oute Number,
	To the Hospital or within 24 hours aft. To the Funeral Dir completed filled in	Medical	(Check 2  Medical E only one) 3  Certifying	xaminer: Dr	the basis of ex	xamination	and/or investi	gation, in	my opinion	date and place, a , death occurred a time, date and pla	at the time, date a	and plac	e, and due to the	cause	(s) and manner stated
	To To		29b. Signature and time of dertifier	w	Cus			29	c. License	3213	6	_	ate signed (Mon		
(	BL		30. Name and address of person v	vho complet	د _ ٠	102	3).		~L	Dri	re ch	ush	r, MO	2	1619
	Stat Registra	e Ir	31. Date filed (Month, Day, Year) SEP 30	2009	32. Registra	ar's Signati	Urg. 400	aks	1						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Day 1. Decedent's Name (First, Middle, Last) Year **Physician** Dura / Fre Largon 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Ellicott Morningside House Ellicott City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🗓 F March28,1915 Nebraska 94 Director 506-50-4217 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Health and Mental Hygiene. em 27 is anarked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exemine Insist by nothing at 1 ☐ Yes 2X No Director Laramie Wyoming Albany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 82070 2418 Crazyhorse Way U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📉 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname, Be ( 17. Father's Name (First, Middle, Last) Jessie Ness Charles B. Coe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5064Blacksmith Drive, Columbia, Maryland 21044 William C.Larson:Son permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wakefield Cemetery 9-29-09 | Wakefield, Nebraska 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee Mar 6009 Harford Road, Baltimore, Maryland21214 michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Thero Celevolu (ardiac Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Endome Se µential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) Ö been signed by the should be detached 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 s autopsy performed e Hospital or Attending Physician: The I 24 hours after death. e Funeral Director: After this certificate ha etely filled in by the funeral director, page? 1 Yes 2 No 1 ☐ Yes 2 🗹 No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assuted Iv, 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certification: 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Seplember 25 2009 1730641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back Rover Medic Road Baltimy Mayle 1124 Kamech 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 25, 2009 Ernestina Ramona Mederos Sept. 1:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5224 Elliott Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/11/1905 9. Birthplace (State or Foreign Country)
Cuba 5. Social Security Numbe 220-70-7869 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗗 F 104 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Modical Evantrer must be notified at Bethesda 11 Yes 2 □ No Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 5224 Elliott Road 20816 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status ified within 72 hours after de la Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 □ No Specify: Cuban Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Childcare Domestic Childcare Giver 12 should be filed w h and Mental Hygier 7 Is marked other th 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Victoria Owens Jose Alberto Mederos traumatic 2 19a. Informant's Name/Relationship (Type. Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heatth and Important: If item 27 Is n any injury or other traun Guillermo A. Belt/Representative 1808 Melbourne Drive Mclean, VA 22101 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/30/2009 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Ligensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardio Pulmonary Arrest disease or condition resulting in death) ) /Medical Due to (or as a consequence of) Examiner Myeloproliferative Disorder 1 Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for an a population of Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the b nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for t in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.0. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖰 Unknown History of Deep Vein Thrombosis page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🔯 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the Pwithin 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 046366

State Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** REBECCA MCCLAIN 9/26/09 20:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, 5/10/20 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 Days Hours SC 89 252-30-5032 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evancinar must be notified at 10a. State 1 X Yes 2 □ No Director Philadelphia PA Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 5933 N. 21st Street 19139 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Youth Director Assistant Church 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Washington Obie Washington, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau once. Carolyn A. Young - daughter 21310 Woodfield Rd, Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗀 Cremation 3 ☐ Removal from State 10/2/09 4 □ Donation 5 □ Other (Specify) Philadelphia, PA ©h∉lten Hills Cem. 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service 246 N. Washington St, Rockville, MD 23a. Part I. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Minutes Immediate Cause (Final Acute Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it are all it is a list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 √No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 2 Accident ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

31. Date filed (Month, Da 30 Registrar

and title of certifier

(Check only one)

John Jones

29b. Signature



MI

dress of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive,

29c. License number

.4088

Rockville, MD

20850

29d. Date signed (Month, Day, Year)

9/27/09

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4	For State Registrar	Olate of Ina	,	Certificate of L			eg. No.	
	Physicia		1. Decedent's Name (First, Middle, Last)  William Miller					2. Date of Deat Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Balty	Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 220–46–6370 6. Sex 1 □ X	M 2□F	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 3	Year) 9. Bir Co 0,1952 Ma	thplace (State or Foreign ountry) ryland
	the Maryianu 28a-f show notified at	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Washingt           10e. Street and Number		10c. City, Town o	Hagerstown		1	0g. Citizen of What Co	10d. Inside City Limits 1 X Yes 2 No puntry?
	h with	a Di		ide Villa	age		21740		United S	tates
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it in most in a near the notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	ver in U.S. P1976	13. Was Decedent of H If Yes, specify Cuba 1 □Yes 🍇 No	ispanic Origin? (Span, Mexican, Puerto Specify:			e,etc. White
9500-6121	vithin 72 ho sne. :han "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+	(9	ecedent's Usual Occup Give kind of work done of ife. DO NOT use retired	ation during most of work f) : Installe	ing	16b. Kind of Business Banking	/industry
yland 2	d be filed v ental Hygie <b>ced other t</b>	Be	17. Father's Name (First, Middle, Last) William W. Mil	_+4 _ler		Computer	18. Mother's Nam		Maiden Surname)	
Mary	nd 2 shoul alth and Me 27 is mark er traumati	ဥ	19a. Informant's Name/Relationship ( <i>Typ</i> Margaret Miller /	e. Print)		Mailing Address (Street 7 Willow Ro				Zip Code)
Baltimore,	Pages 1 a ment of He ant: If item lury or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			Disposition (Name of crematory or other place or Crematory	9/24	/2009	20c. Location - City of	Maryland
Ball	permit. Depart Import any inj		21. Signarule of Funeral Service License	Staulle	Л	1621 Op	ossumtow	n Pike,	uneral Hom Frederick,	
· Production	Physician /Medical		23a Part 1. Enter the disease, or complice shock, or heart fallerfe. List only on Immediate Cause (Final disease or condition resulting in death)					or respiratory an	rest,	Approximate Interval Between Onset and Death
	rificate be executed as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of		si S			
68760,	tificate be ng physicia as the bu	<b>dedical</b>	d							
O. Box	death ce e attendii d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey		23d. Date of d Month	elivery Day Year
rds, P.	es tha	δ	Part II. Other significant containing to doubt out the recently in the analysis and a					pacco use contribute to the cause of death?		
tal Records,	The law ate has b bage 2 sl	<b>Completed</b>	25. Was case referred to medical				26 Place of Dea	24a. Was autop perfor 1 □Yes	prior to death? 2█No 1☐Ye	
f Vital	hysicia his cert I directo	To Be	examiner?			Jatient 3 DOA	ner: 4 🗆 Nursing H	ome 5 Resid	dence 6 □Other (Sp	pecify)
ouo	nding P ith. r: After t e funera	ation:	27. Manner of Death  1 → Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	ry 28b. Ti <i>r, Year)</i> Inj	ury   Wo	ryat rk? ]Yes 2≦No	28d. Describe h	now injury occurred	
Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	iry - At home, farr c. (Specify)	n, street, factory, office		28f. Location (5 City or Tov	Street and Number or a yn, State)	Rural Route Number,
	e Hospit 24 hour e Funera letely fille	Medical (	29a. Certifier (Check only one)	sician: To the best oner: On the basis of and manner sta	examination and	death occurred at the t /or investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	0	121 - P	29c. Licens	se number		29d. Date signed (Mo	-1-0
	14		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (1	Type, Print)	10019	6	71	19/09
	50	to.	Salam Jeuf	32. Registra	72 Sar's Signature	M G-seeve	st. Dat	mor M	D 21301	
	Registi		CED 0 0 20	000	. 1	ha. del				

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			For State Registrar	State of Ma	-	Certificate of I			Reg. No.	
	Physicia	an	1. Decedent's Name (First, Middle, La.		TZADEMI	MILLED		2. Date of Dea Month	er 28, 200	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv	IZABETH	IZABETH MILLER  4b. City, Town, or Location of Death		Septembe	4c. County of D		
j	Examin	er	Northhampton Manc		Home	Frederi			Frederic	
١	Funeral Director		5. Social Security Number 6. S 219–20–1818	ex 7. Age	(In yrs. last birth	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 19	(, Year)	Birthplace <i>(Stat</i> e o <i>r Foreig</i> n Country) aryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryil I-f sho fied al	tor	Maryland Frederi	ck	Freder	ick				1∏Yes 2□No
	th the or 28a e noti	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	s 23a nust b	eral	200 East 16th Sti			21701	lianania Origin? (Sp	posify Vas or No-	U.S.A.	merican Indian,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  The majoritant if the ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it all exited Examiner must be notified at once.	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛣 No	Specify:	Rican, etc.)	Specific	White
ה ה	72 hou natura	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. [	Decedent's Usual Occup Give kind of work done life. DO NOT use retired	eation during most of work	ing	16b. Kind of Busine	ess/Industry
7	within sne.	ldu	Elementary/Secondary (0-12)	College (1-4or 5+	-)	<i>life. DO NOT use retired</i> Bookkeeper	d)		Governm	ent
<b>7</b>	filed v Hygid Sther i	Be Co	17. Father's Name (First, Middle, Last,	)		BOOKKEEPET	18. Mother's Name	e (First, Middle,	Maiden Surname)	
land land	uld be Vental rrked tic ev	To B	James Nathan Dube	21			Bessie M			
, Mar,	and 2 sho raith and I s 27 is ma er traume		19a. Informant's Name/Relationship ( Lawson Dubel / Ne			Mailing Address (Street 02 North 51			le, AZ 85	302
pallimore	Pages 1 annung Hernart: If Item		20a. Method of Disposition 1			Disposition (Name of crematory or other place ivet Cemete		Date 709	20c. Location - City Frederick	or Town, State , Maryland
2911	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	isee	14	ROBERT E.				
	20 = 60		23a Part 1 Enter the disease or com	nlications that caused	the death. Do no	1201 NORTH				Approximate Interval Between
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line	9.					Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to ( as a	consequence of	n:	Ferlin			Day
	Examiner	L	Sequentially list conditions,	b. Cong	estive		Ferlin			Dans
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of	r):				
ń	execu an and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of	f):				
00/00	tificate be execute g physician and as the burial-transit	edical	•	d						
Š	certific iding p		IF FEMALE:	23c. If yes, outcome of	of pregnancy		.,-		23d. Date of	f delivery
.O. BOX	The law requires that the death certificate be execute are has been signed by the attending physician and bage 2 should be detached for use as the burial-trans!	nysician/N	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	cy		Month	
ras, r	luires that n signed b ıld be deta	d by Phy	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause giv	ven in Part I.			te to the cause of death?  Probably 4 🗀 Unknown
Records,	he law rec te has bee age 2 shou	Completed						24a. Was autop perfo 1 □Yes	osy prio rmed? dea	e autopsy findings available r to completion of cause of th? Yes 2 \( \subseteq \text{No} \)
VITAL	ding Physician: The I n. After this certificate ha funeral director, page	Be C	25. Was case referred to medical examiner?		<del>.</del>		26. Place of Dea			165 2 140
> 	hysic this ce al direc	မ	1 Yes 2 No			patient 3 1 DOA			dence 6 Other	Specify)
	ding P	ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day		ijury Woi	ryat rk? ]Yes 2 ∐No	28d. Describe i	how injury occurred	
UNISION	I or Attending Physician: after death. Director: After this certifica d in by the funeral director, p	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	ry - At home, far . <i>(Specify)</i>	arm, street, factory office 28f. Location		28f. Location ( City or Tox	on (Street and Number or Rural Route Number, Town, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and	, death occurred at the t d/or investigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	8		29c. Licen			29d. Date signed (A	
						D4:	3091		9-29	-09
			30. Name and address of person who	Zavidi	MN	Type, Print)	Tou H	onec	Ave Fr	redench MD
	Sta Registr		31. Date filed (Month, Day, Year) SEP 3 0 2		ar's Signature	park			•	

State of Maryland / Department of Health and Mental Hygiene C. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 28, 2009 1520 Katurah Moore Marshall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year 1951 **Funeral** Days 1 □ M 2 🔀 F 58 579-68-9138 January 13, Washington, D.C. Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10b. County 10a. State 28a-f show event, the Medical Examiner must be notified at 1XYes 2 No **Funeral Director** District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20010 United States 3553 - 11th Street, N. W. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Specify: Black 1 □Yes 2X No <u></u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12th grade Homemaker Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event Be Joseph Moore Sallie Mae Cole ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rickey Bernard Marshall (Husband) 1221 Eaton Road, S.E.; Washington, D.C. 20020 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.5,2009 Mount Olivet Cemetery Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Signature of Funeral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that crused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) poalycamic **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 □ No 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by 1 ✓ Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 10 No Vital 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Division of 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director; filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) 29c. License number 47867 and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar 31. Date filed (Month

**OCT 02** 

Baltimore.

Box 68760

P.O.

Zd #216 MD 20852

of person who completed cause of death (Item 23a) (Type, Print)

09-07740						
Evelyn Milhouse						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of L	Death	Reg.	No.	
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death     Month     D	ay Year	3. Time of Death
Medical Examin		EVELIN		October 5, 2	.009	1830 hrs
		,	. City, Town, or Location of Death <b>Waldorf</b>		4c. County of Death Charles	h
	4	Troop troy modern or an income	If Under 1 Year   If Under 24Hrs	8 Date of Birth/		rthplace (State or
Funeral Director	1		Months Days Hours Min.			rthplace (State or glwashington
Bileotor	-	578-64-1853 1 M 2XF 61 Yrs.		3/16/19	948	DC DC
any		Usual Residence of Decedent  10a. State 10b, County 10c. City, Town or Location				10d. Inside City Limits
* .	.	10a. State 10b. County 10c. City, Town or Location Waldorf  Maryland Prince Coorge! S Hoper Maryl				1 X Yes 2 No
4aryland 28a-f show Lat once.	홠	Maryland Prince George's Upper Marl	10f. Zip Code	10g	. Citizen of What Cou	untry?
or 28	Director	11000 II. W . I G # 207	20.602			
vith the s 23a s 23a	듥	11.080 Wey Mouth Court # 307	20603 Decedent of Hispanic Origin? ( Sa		nited Stat	rican Indian, Black,
death with the Maryland or items 23a or 28a-f sho	Funeral	1 Never Married 2 Married Armed Forces? If Yes 1 Yes 2 No	, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
frer d			es 2X No specify:		Specify: B1a	ack
ours a atura tamit	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's during meeting and during meeting meeting and during meeting	Usual Occupation (Give kind of v		6b. Kind of Business.	/Industry
6 ra "n ra "n cal E	et	Elementary/Secondary (0-12) College (1-4 or 5+)	t of working life. DO NOT use rea	160)		
5-0036 led within 7 Hygiene. other than	Ĕ.	Clerk			Private	
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2121 ould be fi Mental J marked	To Be	William E. Miller  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing A	Laura Be	rtha Frv	e. er. City or Town, Stat	e. Zip Code)
MD 3	٦(	for the second s	udor Road Upper			17
and 2 and 2 lealth item 2 traus		20a. Method of Disposition 20b. Place of Dispositi	on (Name of cemetery,	Date	20c. Location - City c	or Town, State
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Cremation 3 Removal from State crematory or othe	· ′ 1			
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Balti permit. Departr Import injury	- 1	1 000 CULV 1553	rope 8 Marlhoro Pika	Foresty	Homes, P.	A
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/Medical	1	failure. List only one cause of each line. Probable Tramadol Immediate Cause (Final disease / a. associated with Hy	and Cyclobenza pertension	prine in	LOXICACIOI	Death
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Box 68 e death certif the attending ed for use as	icia	past 12 months?  4 Pregnant at time of death 5 Other	er (Specify)			
Bo e deat the at	Physician	1 Yes 2 No 9 V Unknown g Unknown	· · · · · · · · · · · · · · · · · · ·			
, P.O. Box 68' res that the death certification is signed by the attending be detached for use as	by P		derlying cause given in Part I.			o the cause of death?
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ing Ph		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)		28d. Describe ho	ow injury occurred	
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Division of Vital Records, P.O. Into rattending Physician: The law requires that the rs after death.  "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ertification	3 Suicide 6 X Could not be determined (Specify) rosidence	, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or I ate) 11080 We	Rural Route Number, City  rymouth Ct. Co,Md. #307
Life in boundary	아	29a Certifier				
in 24 he Fu	ical	(Check only 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation	occurred at the time, date and place, and due to the cause(s) and manner as stated. Stigation, in my opinion, death occurred at the time, date and place, and due to the ca			the cause(s)
15 th 15 th 100	Medical	and manner stated.  29b. Signature and title of certifier		29d. Date signed (A		
	_	him how, wo	29c. License number O.C.M.E.		October 7, 200	_
		30. Name and address of person who completed cause of death (Item 23a)				
_			, Baltimore, MD 21201			
Sta	ate					
Registi	rar					

	1	For State Registrar		yland / Depa <i>Ce</i>		of Death		Reg. No.			)   .
lhinin.m		1. Decedent's Name (First, Middle, L	***				2. Date of De Month	ath Day	Year	3. Time of	Death
hysician /Medical		Brian A.	Mundy				Septem			3:45	a <sup>l</sup>
xaminer	•	a. Facility Name (If not institution, g	ve street and number)		4b. City, Tow	n, or Location of De	ath		nty of Death		
		417 W. Main St				itland			comico		
ineral rector		5. Social Security Number 6. 216-90-2642  Usual Residence of Decedent	Sex 1X M 2 □ F 7. Age 38	(In yrs. last birthday) Yrs.	If Under 1 Ye	ear If Under 24 H ays Hours M		th y, Year) /1971	Cour	place (State of htry) yland	r Forei
MC #	- 1	10a. State 10b. County		Oc. City, Town or Lo	cation				1	0d. Inside Cit	ty Limi
28a-f show	בנוסו	Maryland Wicom	ico	Fruitlan	_					1 XYes	2 🗆 N
r items 23a or 28a-f st ilicar must be rofffied Funeral Director	<u>a</u>	10e. Street and Number 417 W. Main St	reet		10f. Zip Co	3 <b>2</b> 6		10g. Citizen d USA		ntry?	
ems er m		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. F	lace - Americ		
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examinations to one.  To Be Completed by Funeral Dis	, and	1  Never Married 2  Married 3  Widowed 4  Divorced	1 ∐Yes 2 🔀 No If Yes, Give Year or Dates:		1⊡Yes 2 <b>√</b>			Spe		ite	
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arked ott atic even To Be	ו בֿ	17. Father's Name (First, Middle, Las Michael D. Mund					ame (First, Middle, Try L. Bal		ame)		
27 Is m er traum		19a. Informant's Name/Relationship Sherry Mundy/mo		19b. Mailii <b>417</b>	ng Address (St W. Ma	reet and Number or in St. Fru	Rural Route Numbe itland, l	er, City or Tov MD 2182	vn, State, Zip 26	Code)	
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Important any injury once.		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Springhil Garden			/30/09 Home Pro		on, MD onal As	sociat	ior
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ed by the attending printer by the attending printer as the detached for use as the action of the ac		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d.	Date of delive	ery	
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Arter ruis certificate has been s funeral director, page 2 should tion: To Be Completed							24a. Was – autor perfo 1 □ Yes		<ul> <li>b. Were auto prior to co death?</li> <li>1 \( \sum Yes \)</li> </ul>	psy findings a mpletion of ca	availab ause of
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al Director: After led in by the funera		3 Suicide 6 Could not 4 Homicide determined		- At home, farm, str (Specify)	eet, factory, off	ice	28f. Location (S City or Tox	Street and Nu wn, State)	mber or Rura	al Route Num	ber,
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Сопр	-	OOL Oissant as and title of southing	7		29c. Lie	cense number		29d. Date sig	ned (Month,	Day, Year)	
2		30. Name of address of pers. who	at . M	0.	Z	130696	,	Sept.	29,	2009	
March 1	13	30. Name and address of person who	completed cause of dea	th (Item 23a) (Type,	Print)						
S		4-			_		61 5	1. /		111	2 (

09-07805	
John Orr	

9-07805 ohn Orr		Please Type or Print in Black Indelible Ink. Ensure All Cop State of Maryland / Department of Health and Mental	Luciono
		1- For State Registrar 1. Decedent's Name (First, Middle,Last)	Reg. No.  12. Date of Death  3. Time of Death
Physici ledical Exami		John Ellis Orr, II	Month Day Year 2130 hrs
)		4a. Facility Name (if not institution, give street and number)  University Hospital  4b. City, Town, or Location of De Baltimore	
Funeral Director		213-27-2227 1X M 2 F 21 Yrs.	Min. 06/04/1988 Foreign Countr MD
id how any	_	Usual Residence of Decedent  10a. State	10d. Inside City Limits 1 Yes 2 No
the Marylar a or 28a-f s	Director	10e. Street and Number 12626 Ridgely Road 21639	10g. Citizen of What Country? USA
215-0036 be filed within 72 hours after death with the Manyland that Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes, Specify Cuban, Mexican, Put	( Specify Yes or Noerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Caucasion  Specify:
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15. Decedent's Education (Specify only highest grade completed)  College (1-4 or 5+)  3  Student  Student	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Com	Gerald Douglas Orr	ame (First, Middle, Maiden Surname) ie Marie Sharp
MD 21  rd 2 should lath and Mer m 27 is man	To	Gerald D. Orr / father 12626 Ridgely Rd	or Rural Route Number, City or Town, State, Zip Code)  One of the control of the
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked injury or other traumatic event, til		4 Donation 5 Other Specify:	20c. Location - City or Town, State 10/11/09 Church Creek, MD
Balt Bernit Depart Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	Detweel Oliset all
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0, e be execut sician and burial - trai		X UNPENDED X AMENDED 28a-b, per ME g899 1/11/10 #1 as noted, 23a,27,28a-f,p	TT DerME, g898 12/29/09 TT 23d. Date of delivery
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Divector. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed		24a. Was an autopsy findings available prior to completion of cause or death?  1  Yes 2 No 1 Yes 2 No
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on of Virtual Physical  ion: To	1 V Yes 2 No Inpatient 2 EROutpatient 3 DOA 4 N  27. Manner of Death 1 Natural 5 Pending 1 Natural 5 Pending	lursing Home 5 Residence 6 Other:  28d. Describe how injury occurred  unk	
Divisic ital or Atter irs after deat al Director led in by the	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined 4 Homicide Fd 10/7/09 Fd 9:25 pm 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) unk	28f. Location (Street and Number or Rural Route Number, Coor Town, State)
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	29a. Certifier (Check only one)  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated,	and due to the cause(s) and manner as stated.
To To Cor	Ne I	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)

31. Date filed (Month Park)

30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner Jack Titus MD.

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

State Registrar

October 8, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23b pestale of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Janice Oberhaus 00.58 M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 491-24-7905 Months Hours 10/24/1927 81 Missouri Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director MD Washington Hagerstown 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27777 Sunbrook Lane 21742 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐**\**¶No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonard Swanson Wilberta Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Bowlus (Daughter) POB 258, Buckeystown, MD 21717 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Mile PN) in the Police (Name of Other Place) Date 20c. Location - City or Town, State 1 🗌 Buria 2X Cremation 3 Removal from State ion 5 Other (Specify) Crematory 9/28/09 Hagerstown, MD Bonard AdB. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each lice. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 1 rutors Medical Due to (or as a consequence of): **Probable** Examiner Sequentially list conditions, it any leading to formediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of): ng physician ar as the burial-t Physician/Medical Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) the P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has but director, page 2 sh autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate P completed filled in by the funeral director, page 2 🗌 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FUSON

2009 ▶

32. Registra s Signature

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene

Descents Name (First, Middle, Last)   JEANETTE R. OWENS   JEANET				For State Registrar	Otato or ivi	-	Certific		Death	Worker 11	Reg. No.	Z. [] t	3 33	075
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23a. Part 1. Einer the diseases of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition) resulting in death)  25a. Part 1. Einer the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition) resulting in death)  25a. Part 1. Einer the diseases or cardian in the cause on each line. It or of one cause on each line and one cause of one cause of one cause of one cause. It or one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause. It or one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause of one cause of one caus	Š	alth a		Jenshel Owens Mar	shall / D	aughter	1142 F	Booker	Drive (	Capital	Heigh	nts, Ma	ryland :	20743
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Physician   Medical   Examiner				23a. Part 1. Enter the disease, or com	plications that cause	d the death. Do							Approximat Interval Bet	e
The first conditions of the part of the pa	E. F	hvsician		Immediate Cause (Final									Onset and	Death
Sequentially list conditions, leaves the property of the part of t		/Medical		resulting in death)	a			211						
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The color of the		p ±	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):							
The color of the		ecute and -trans	xam	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):							
The Females   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23d. Date of delivery   Month   D   23d. Date of delivery   D   23d. Date of d	. 60	sician buria			d	a consequence	<i>,.</i>							
The Females   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   23d. Date of delivery   Month   D   23d. Date of delivery   D   23d. Date of d	89	ifficate g phy as the	edic		u									
Solve the state of	O. Box	he death cert the attendin thed for use a	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ⅨNo	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death			Sy				-	Year
Solve the state of	σ.	that ned by deta		Part II. Other significant conditions	ontributing to death t	out not resulting i	n the underlyi	ng cause giv	en in Part I.	23e. Did	tobacco (	use contribute	to the cause of	death?
Solve the state of	sp.	quires n sigr ald be		CORONARY ARTERY	DISEASE					. 10	Yes 2	□ No 3 □ F	Probably 4 🔀	Unknown
Solve the state of	Reco	ie law rec has bee ge 2 shou	mplete	CHRONIC OBSTRUCT	TIVE PULMO	NARY DI	SEASE	_		- aut	opsy formed?	prior to death?	completion of	available ause of
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Solve the state of	n of	ng Phy fter thi	⊢	27. Manner of Death			Time of						0011) 110 01	
Solve the state of	Sio	tendii eath. or: A the fu	catic	2 Accident investigation					Yes 2 □ No					
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Date of the course)  29d. Date signed (Month, Date of the course)	<u> </u>	I or Att after d Direct I in by	ertifi	datarminad	20e, Flace of III	jury - At home, fa tc. <i>(Specify)</i>	arm, street, fa	ctory, office					Ru <b>r</b> al Route Nur.	nber,
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L. Lougetchin My NG 71,3		To the vithin To the complex	Me		0			29c. Licens	se number		29d. Da	ate signed (Mor	nth, Day, Year)	
7/20/2007		, ,,,		J. Louder	hou, M	IJ		163	3743		9/2	8/2009		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		5		30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)				-12	2,200		
Jocelyne Kouatchou 6001 Muncaster Mill Rd. Rockville, Maryland 20855	7							Rd. I	Rockvill	e, Mary	land	20855		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar  CED 2 0 2009					32. Regist	rar's Signature	Les!							

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Ce	rtificate of	Death	Re	eg. No.	3 30//
			Decedent's Name (First, Middle, La.	st)				2. Date of Deat	h	3. Time of Death
	Physici /Medi		John Howard	Ostrander				Septembe	er 28,200	5:00A M
may.	Examir		4a. Facility Name (If not institution, giv				or Location of Death	)	4c. County of I	
and the			Charlotte Hall	Veterans Home			otte Hall			lary's
H	Funeral Director		5. Social Security Number 6. S 068–18–0912	ex 7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, August	5,1923 N	Birthplace (State or Foreign Country) Iew York
	p ,		Usual Residence of Decedent	140.0	Ŧ					10d. Inside City Limits
	shov	ř	10a. State 10b. County		ty, Town or Lo					1 √2 Yes 2 □ No
	Ba-f	ecto	MD Charles	5	La Pl				0 000	Λ
	vith th	늅	10e. Street and Number 310 Caroline Dr:	irro		10f. Zip Code	0646	1'	0g. Citizen of Wha	it Country?
	s 23	eral			0 140			nasifu Van or No		American Indian,
980	be filed within 72 hours after death with the Maryland that Hygiene.  4d other than "natural", or items 23a or 28a-f show event, it is Medical Examire must be rediffed at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ZYes 2 ☐ No If Yes, Give Year or Dates:	- 1	was Decedent of If Yes, specify Cult 1 □ Yes 2 🛣 No	Hispanic Origin? (Span, Mexican, Puerton Specify:	o Rican, etc.)		White etc. White
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest gra	ducation		dent's Usual Occu	pation during most of work		16b. Kind of Busin	ess/Industry
21215-0036	d within giene. <b>sr than</b> "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retire	<sub>ed)</sub> ty Office:		US Nav	<i>r</i> y
Maryland	be eve	Be	17. Father's Name (First, Middle, Last, John Ostrander				18. Mother's Nam Isabell	ne <i>(First, Middle, N</i> Hanley	Maiden Surname)	
<u></u>	shoul nd Ma mark	ပ	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Stree	t and Number or Ru	ral Route Number	; City or Town, Sta	nte, Zip Code)
Š	12 mg		Deborah Beck/Daus		930	Orange V:	iew Drive	. Largo.I	FL 33778	3
ē,	item othe		20a. Method of Disposition	20b. I		sition (Name of matory or other pla			20c. Location - Cit	y or Town, State
Baltimore,	permit, Pages 1 Department of I Important: If ite any injury or of		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State	lingto	n Nationa	al   11/			a,Virginia
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licer	M01458	22		≌ጀሮክቼቼ FI Mary's A		-	20646
			23a. Part 1. Enter the disease, or construction shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not ent	er the mode of dy	ring, such as cardiad	or respiratory arre	est,	Approximate Interval Between
ď.	Physician		Immediate Cause (Final disease or condition	ACUTE	CARD	IAC A	RRHYTH	MIA		Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	uence of):	89				
	Examiner	L	Esquentiany list somultions.	, CONGESTI		MEART	FAILU	RE		
	ed sit	Examiner	Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec		0 - 0 110	× 105 A			
	ecut and -trans	хаш	that initiated events resulting in death) Last	c. CORONAR Due to (or as a consec		RTERY	DISEA	SE		
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σ.	that ned by detail		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause gi	iven in Part I.	23e. Did tob	bacco use contribu	ite to the cause of death?
rds	uires n sigr id be	d by	CHRONIC R	ENAL FAI	LURE			1 □ Ye	es 2 🗆 No 3[	☐ Probably 4☐ Unknown
Ö	w requires to be a signer should be a	ete						24a. Was a	n 24b We	re autopsy findings available
al Re		Completed						autops perforr 1 □ Yes	y prio med? dea 2 ☑ No 1 ☐	r to completion of cause of th? Yes 2 ☐ No
ξ		Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	hor:	th (Check only on		
ō		<u>1</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatier 28b. Time o	IL 3 LI DOA	4 Lundrsing H		ence 6 Other	(Specify)
on	ding Ph h. After th funeral	ţi	1 ☑ Natural 5 ☐ Pending	(Month, Day, Year)	Injury	Wo	ork? ∐Yes 2∐No	200. Describe ne	on injury occurred	
-	al or Attending s after death. I Director: Afte d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		l ome, farm, str fy)			28f. Location (St City or Town		or Rural Route Number,
	the Hospital or At thin 24 hours after d the Funeral Direct mpletely filled in by		(Check only 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina						
	o the Fithin 24 or the Formplet	Medical	one) 29b. Signature and title of confider	and manner stated.			ise number		9d. Date signed (/	

State Registrar RAO

MD

29c. License number

29d. Date signed (Month, Day, Year)

20854

D67788

28 12009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEENA KODALI 8578 Brickyard Rd.Potomac,MD

31. Date filed (Month, Day, Year)

SEP 30 2009



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 28, 2009 Physician 12:55 p M Margaret R. Pfanstiehl /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Hebrew Home of Greater Washington 8. Date of Birth (Month, Day, Oct. 10, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Months Days 1932 Virginia 220-50-7451 76 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b County 1 ☐ Yes 2 No must be notified Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20901 426 Branch Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes ŽŽ No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) President/CEO Non-Profit Organization 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Crystal Gillian Everyn Woodland ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8120 Woodmont Avenue, Suite 650, Bethesda, MD 20814 Francis E. Yeatman/Executor other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. September 30 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 2009 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, all one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MADNIC **Physician** /Medical Due to (or as a consequence of) Examiner Se mentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has performed 21 No To the Hospital or Attending Physician: 25. Was case referred medical examiner? 26. Place of Death Check onl one Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 ☐ Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation within 24 hours amer co...
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Can 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 6121 MONTROSE 31. Date filed (Month, Day, Year) State

Registrar

3altimore, Maryland 21215-0036

Division or Vital Records,

			For State Registrar	State of Mary		rtificate of D			Reg. No.	2005	33079
	Physicia		1. Decedent's Name (First, Middle, La Karen Marie Phea	•				2. Date of Dea Month		2 Year	3. Time of Death 3:51 AM
-	Medic Examin		4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, or		<u>LIOUCI</u>		County of Dear	
			Washington Count	y Hospital		Hagers	town			Washin	gton
	Funeral Director		5. Social Security Number 6. S 213-68-5911 1  Usual Residence of Decedent	6ex 7. Age (In ) ☐ M 2 🔀 F 54	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day April	h , Year) 6 <b>, 1</b> 95	9. Bir Co Ma	thplace (State or Foreign untry) aryland
	and show fat	ō	10a. State 10b. County	100	. City, Town or Loc	cation					10d. Inside City Limits
	Maryl 28a-f otified	Director	Maryland Washi	ngton	Boonsb	oro					1 ☐ Yes 2 🛣 No
	n with the is 23a or and inst be n	Funeral D	10e. Street and Number 7503 Fairplay Ro	ad		10f. Zip Code	21713		10g. Citize	en of What Co A	ountry?
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	12. Was Decedent Ever in Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates.		Was Decedent of His f Yes, specify Cubar		cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit pecify:	
15-(	72 hou n "nat fedica	nple	15. Decedent's E (Specify only highest gr		(Give I	dent's Usual Occupa kind of work done do	ition uring most of worki	ng	16b. Kind	d of Business	Industry
212	vithin jiene. er thai		Elementary/Seconday (0-12)	College (1-4 or 5+) 2		ONOT use retired)  1tor			rea	1ty	
	filed valued of othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Su	ırname)	
yla	should be filed with h and Mental Hygien 7 is marked other t traumatic event, th	မ	James O. Frey				Melodie —	e L. Bro	own		
, Maryland	and 2 shou Health and tem 27 is n		19a. Informant's Name/Relationship (7 Scott Frey - bro	ther	1754						o Code) and 21213
Baltimore,	Page 1 a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Db. Place of Dispos cemetery, crem Bakersvi	natory`or other place	10/5	5/09		ation - City or rsvill	
Ball	permit Depart Import any in		21. Signature of Funeral Service Licen:	m ·	//	. Name and Address		MINNICH			
		$\vdash$	23a. Part 1. Enter the disease, or com	plications that caused the		15 E. Will				n, Md.	
			shock, or heart failure. List only of	phoations that caused the	death. Do not crite	of the mode of dying	, such as cardiac o	respiratory arr	cot,		Approximate
7	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		ratory 1	ailure,	myoca	rdial	Infai	chan	Interval Between Onset and Death
7			Immediate Cause (Final disease or condition resulting in death)	a	'. 01	- 4		rdial	Infar	chin	Onset and Death
-	Medical Examiner	niner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reauring to immediate cause. Enter Underlying	a	'. 01	- 4		ndial	Infai	rchin	Onset and Death
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Division of Vital Records, P.O. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed  1.4 hours after death.  1.5 Funeral Director. After this certificate has been signed by the attending physician and  1.5 Funeral Director, page 2 should be detached for use as the burial-transit  1.5 Funeral Director, page 2 should be detached for use as the burial-transit  1.5 Funeral Director, page 2 should be detached for use as the burial-transit  1.5 Funeral Director, page 2 should be detached for use as the burial-transit  1.5 Funeral Director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any, leauning to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as a con  b. Due to (or as a con  c. Due to (or as a con  d. Immur  23c. If yes, outcome of pre  1 Live Birth 2 —  4 Pregnant at time  9 Unknown  ontributing to death but no  umword an  pary Biliary  Letter me  Hospital:  28a. Date of injury  (Month, Day, Yea	sequence of):  any factors  sequence of):  equence of): sequence of): sequence of): sequence of)	Ectopic pregnancy Other (specify)  26. Plant 3 DOA  28c. Injury work? M 1 N  Deet, factory, office	ce of Death (Check  4  Nursing Horat  at  //es 2 \sum No	23e. Did to  1 1 2  24a. Was a autop perform 1 1 Yes  only one)  me 5 Resid  28f. Location (S City or Tow.)	bacco use fes 2 Inn sy med? 2 No ence 6 Downinjury of treet and N n, State) use(s) and r d place, ar	and Date of de Month  Solution of the Month  Solution of the Month of	Onset and Death one week  One week  Two weeks  Years  Itivery Day Year  In the cause of death?  Introposition of cause o
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an	James Juli		dum						Month Sept.	25.	ay 200	Year	1:13A
cal	4a. Facility Name (If not institution, g				4h Cit	v. Town, or	r Location	of Death	вере.			of Death	
er	Shady Grove Adv			1		Rockv		or Bouin		"		tgom	
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	Usual Residence of Decedent								1000	, -	, , , ,	1101	Jeana
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Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		Farme						Da	iry	
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o Be	James Willia	am Purd	11.00					Ju1	ia Dav	715			
2	19a. Informant's Name/Relationship		uni	19h	Mailing Addre	ss (Street	and Numb		al Route Numb		or Town.	. State. Zi	in Code)
	D. Lorraine Puro		fe	1	3726 St								yland 208
	20a. Method of Disposition								Date	20c.	Location -	- City or T	own, State 20871
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Its Medical Evaning content and Demotified an once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

30. Name and address of pason who completed cause of death (Item 23a) (Type, Print) Amy Schiffman M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month Day

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 29 2009 **Physician** Lillian D. Paige Sep 5:00am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 119 68th Place Seat Pleasant Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 K F Yrs. 244-36-9775 92 28 Sep North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Even, the hourist by notified at 1X Yes 2 □ No Director MD Prince George's Seat Pleasant 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 119 68th Place 20743 Funeral U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Even 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2K No Specify. <u>چ</u> 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caterer/Domestic Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Debnam Mamie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 119 68th Place, Seat Pleasant, MD 20743 Marion Paige Exum/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Carolina Biblical Ceme 10/5/2009 4 ☐ Donation 5 ☐ Other (Specify) Garner, NC 22. Name and Address of Facility J.B. Jenkins Funeral Home Signature of Funeral Service Licensee 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic colon cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ∃Yes 2⊠No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1∐Yes 2∰No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760 Division of Vital Records,

Baltimore, Maryland 21215-0036

within 24 hours a

Daniel H. Waterman, MD, FACP, 660 Pennsylvania Ave., SE, Washington, DC 20003 31. Date filed (Month, Day, Yea. OCT 0 1 2009

1 and de Waterman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

6 Could not be determined

3 Suicide

29a, Certifier (Check only one)

ca

State Registrar

4 Homicide

29b. Signature and title of certifier

TXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

007654

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

09-07697		
Francisco	Patino	

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 3, 2009 1947 hrs **Medical Examiner** Francisco Patino c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Seat Pleasent 6204 Addison Road if Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Ecuador If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Jan. 25. Country) 1Х м 45 Yrs 604-24-9819 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 X No 23a or 28a-f show Washington notified at once. DC Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20011 1104 Jefferson St. N.W. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 X Married Yes 2 X No 1X Yes 2 No specify: Ecuadorian White Specify: If Yes, Give Year Widowed Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "injury or other traumatic event, the Morkal E 21215-0036 Self-Employed Plumber 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Luisa Guachagmira Luis Alfredo Patino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 2 #A3 Washington DC 20011 Luz Marina Males de Patino 1436 Tuckerman St. N.W. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore, X Burial crematory or other place) 2 Removal from State Ecuador 10-16-09 Family Cemetery Other Sp Donation 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. Funeral Servi Lunsee 3447 14th St.N.W. Washington, DC 20010. Approximate Interval for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death /Medical Acute alcohol intoxication diate Cause (Final disease xaminer condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical 23a,27,28a-f,perME, g896 10/20/09 TT X UNPENDED AMENDED physician the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death been signed by the attending hould be detached for use as 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ş 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has performed? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death 26 Place of Death (Check only one funeral director, 25. Was case referred to medical æ Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 ✔ Other: Scene DOA ER/Outpatient 3 Inpatient 2 2 1 V Yes 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 27. Manner of Death Certification: subject ingested alcohol 1 Yes 2 X No 1 Natural Pending Director: d in by the fi Fd 10/3/09 Fd 7:00 pm 2 X Accident 28f. Location (Street 672 04mbea of Bural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc completely filled in by Could not be or Town, State) Suicide house Seat Pleasant To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 4, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner

State Registrar

State of Maryland / Department of Health and Mental Hygiene

				ertificate of Death		J. No.	0000
	Physici	an	1. Decedent's Name (First, Middle, Last)  Chamles Bhomes Druitt Cr		2. Date of Death Month OCT 6	Day 2009 ear	3. Time of Death 3:30P M
	/Medic	al	Charles Thomas Pruitt Sr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	000. 0	4c. County of Death	
المار	Examin	ier	3631 Dublin Road	Darlington		Harford	
ı	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 2 1 9 - 28 - 3 4 5 4 Yrs. Usual Residence of Decedent	// If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) 9 / 23 / 19	(ear) 9. Birth Cou Mar	place (State or Foreign ntry) yland
	yland Now		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	e Mar 8a-f st	ctor	MD Harford Darlin				1 ☐ Yes 21 No
	3a or 2	Funeral Director	10e. Street and Number 3631 Dublin Road	10f. Zip Code 21034	100	g. Citizen of What Cou USA	
	r death	nner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
2-0030	ours afte ral", or it Exemin	þ	1 □ Never Married 2 ▼ Married 1 ▼ Yes, Give Korea 3 □ Widowed 4 □ Divorced Year or Dates: Era	1 ☐ Yes 2 ☐ No Specify:			hite
7	in 72 h n "natu de fica	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	ing	6b. Kind of Business/Ir	
7 7	ed with ygiene ier thai	Com	12	nager		utomotiv	e Parts
yland	uld be file Mental H arked oth	To Be	17. Father's Name (First, Middle, Last)  John Arch Pruitt		e (First, Middle, Ma		
, Mar	and 2 sho ealth and 1 27 Is mi er traum:		Shirley M. Pruitt/Wife 3631	iling Address (Street and Number or Rur 1 Dublin Road, I	arlingt	on, MD	21034
тоге	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is fivelical Examinar must be refilled at once.		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	cosition (Name of ematory or other place) Home.Cemet. 10/1		oc. Location - City or T Airville,	
Dalillino	permit. Departh Importa any inju		21. Signature of ruler Il ervice Licens  Ci Covert Hollinson	22. Name and Address of Facility larkins F.H.Inc.	,600 Ma	in St.De	lta,PA
		2 8	23a. Part 1. Enter the disease, o complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a.  Due to (or as a consequence of):	Renar.			
h	Examiner	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):			-	
	scuted nd transit	Examiner	that initiated events c				
09/00	rtificate be executed ng physician and as the burial-transit	ical Ex	resulting in death) Last  Due to (or as a consequence of):  d.				
X	certifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	Non-
0. 0.	the death of the attenched for us	Physician/Medical	in the past 12 months? 1 Live birth 2 Fetal death 3	B ☐ Ectopic pregnancy □ Other (specify)		Month	Day Year
cords, P.	uires that signed b	5	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Tecol	e law req has beer ge 2 shou	Completed			24a. Was an autopsy perform	prior to c	topsy findings available ompletion of cause of
VITAL	an: Th rtificate tor, pag	O	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2,	No 1 □ Yes	2 ANO
01 <	hystci this ce al direc	To B	examiner? 1   Yes   Hospital: 1   Inpatient 2   ER/Outpati			nce 6 Other (Spec	sify)
00	ding F th. After funera	tion:	27. Manner of Peath 1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation 22.	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe hov	v injury occurred	
DIVISION	l or Atter after deat Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
_	To the within To the complex	Me	29b. Signature and title ocertifier Ven KATA J. Parsa M	200 Dlola a12	. 29	d. Date signed (Month	, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type Venkata J. Parsa, 601 Atwood Rd.,	e, Print)	MD 21014	4	1
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	fared			

10%

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryland		tificate of D			j. No.	00004
Ь	Physici	an	1. Decedent's Name (First, Middle, Las					Date of Death     Month	Day Year	3. Time of Death
	/Medic		Lucia Ann	Rogerson				Sept.25		3:15p <sup>M</sup>
4	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Lo			4c. County of Deatl	
	C - 120 - 1 - 1 - 1	-4	Mariner Heal  5. Social Security Number 6. Se		ast hirthday)	Bethe:		8. Date of Birth	Montgo	omery  hplace (State or Foreign
Vie.	Funeral Director		217-44-5099	_M 2⊠F 65	Yrs.		Hours Min.	6. (Month, Day, ) 5/23/1	944 Ne	braska
	aryland show d at	_	Usual Residence of Decedent  10a. State 10b. County MOntgom		Town or Local					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma 28a-f	ecto	10e. Street and Number			10f. Zip Code		10/	a. Citizen of What Co	
	th with 1 23a or 3 ust be n	Funeral Director	5721 Grosvenor	Road		20814			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.8 Armed Forces? 1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:		Was Decedent of Hisp f Yes, specify Cuban, I □ Yes 2⊠ No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	in 72 hou n "natura ledical E	Be Completed	15. Decedent's Ed (Specify only highest grad	te completed)	16a. Deced (Give life. L	lent's Usual Occupati kind of work done du DO NOT use retired)	on ring most of work	ing 16	6b. Kind of Business/	Industry
212	yiene.	m <sub>o</sub>	Elementary/Secondary (0-12)	College (1-4or 5+)	Den	tal hygi	enist_		Dentist	ry
and	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last) George W. Dun	n Jr.		1		e (First, Middle, Ma Louise	aiden Surname) e Tidball	
Maryland	and 2 shoul ealth and Me n 27 Is mark	ř	19a. Informant's Name/Relationship (7) George W. Dunn		1	-			City or Town, State, 2	Zip Code) a, MI 48893
Baltimore,	Pages 1 and 2 nent of Health ant: If item 27 I		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specify	nemoval from State	lace of Dispo emetery, cren hesap	sition (Name of matory or other place) beake Cre	m. 9/2		Oc. Location - City or Beltsvi	
Baltii	permit. F Departm Importar any injur		21. Signature of Large Service Licen		PH	Tarmer apod Aphlicas	TNALDI	FUNERA	L SERVIC	
	3.5		23a. Part1. Enter the disease, or compensor, or heart failure. List only of		. Do not ente	er the mode of dying,				Approximate Interval Between Onset and Death
9	Physician /Medical Examiner		disease or condition resulting in death)	a. Multiple Due to (or as a consequ		clerosis				UNKNOWW
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a consequ	ience of):					
5	xecuted and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ience of):					<u> </u>
68760,	tificate be executed ig physician and as the burial-transit	edical E		d						
Division or Vital Records, P.O. Box 6	sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf pregna 1□Live birth 2□Fetal 4□Pregnant at time of do 9□Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
٠ <u>,</u>	s that t ned by e detac	y Ph	Part II. Other significant conditions of			A .		23e. Did toba	acco use contribute to	the cause of death?
g	quires	q pa	Hypothyvoidi.	sin, dement	in,	Poor into	ake,	1 ☐ Yes	s 2□No 3□Pr	robably 4 Unknown
Reco	The law re te has bee age 2 sho	Completed by	Adult fair	live to the	rive	-		24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
ţ	ian: rtifica stor, p	BeC	25. Was case referred to medical				26. Place of Deat	h (Check only one	-	
>	hysic this ce al direc	TO E	examiner? 1 □ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	nt 3 DOA Other	4 Nursing Ho	me 5 ☐ Resider	ice 6  ☐Other (Spe	cify)
n o	ing P		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?		28d. Describe how	v injury occurred	
Visio	or Attending Physician: The after death.  Director: After this certificate ht	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str		es 2□No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
<u></u>	To the Hospital or within 24 hours all er To the Funeral Dir completely filled			ysician: To the best of my kno						
	he Hc in 24   he Fu pletel	Medical	(Check only and Medical Examone)	iner: On the basis of examina and manner stated.	tion and/or in					
		Σ	29b. Signature and title of certifier			29c. License	number 43/2/	29	d. Date signed (Mont	th, Day, Year)
	3		Chow all	moleted earner of death ("	22a\ (T:==	Print)			09/27/0	1
			30. Name and address of person who	HURY, MD, 15	216 1	DINO DRI	VE; BU	RTONS	ILLE, N	1020866
ľ	Sta Regist		31. Date filed (Month, Day, Year)	33. Registrar's Signa	ture	11.0				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, C

		For	Plea A	ise Type mend <sub>Stat</sub>	or Pri	nt in B per M arylan						II Copies Ilental Hy	s Are	e <b>Leg</b> i	ible.	M8085
		1 - State Registrar						Pertifica	te of	Death		T	Reg. N	io.	- 21	
Physicia	an.	1. Decedent's Name	e (First, Midd	le, Last)								2. Date of D	D	ay	Year	3. Time of Death
/Medic				Getu	Adrian	os Ro	ba					Sept.		ر مرجو	23,20	267 1625™
Examin	er	4a. Facility Name (/	f not institutio	n, give street ar	d number)	)		4b. City	y, Town, o	r Location	of Death		4	c. County	of Death	
		981		Place	7 4	un den seen d	look binkbal	(aux) If I Ind	er 1 Year	ollege If Under		8. Date of B	irth	Pr		George's
Funeral		5. Social Security N		6. Sex 1 ♣ M 2 □		ge (In yrs. I. 43		Months		Hours	Min.	(Month, D May 28	av. Year	r) 56	Cou	hiopia
Director		215-35-26 Usual Residence of				45						riay 20	, 170		100	пторга
yland		10a. State	10b. County			10c. City	y, Town or	r Location								10d. Inside City Limits
Mar a-fsl	ctor	Maryland	Princ	ce George	s				C	ollege	Park	į				1 ☐ Yes 2 🖾 No
or 28	Director	10e. Street and Nur	mber					10f. Z	ip Code				10g. C	Citizen of	What Cou	intry?
23a		9817	52nd 1	Place						20740					U.S	S.A
r dez	Funeral	11. Marital Status		Arme	ed Forces?		S. 1	13. Was Dec If Yes, sp	edent of F ecify Cub	lispanic Or an, Mexica	rigin? (Sp n, Puerto	pecify Yes or N Rican, etc.)	lo-		ce - Amer ck, White,	ican Indian, etc.
s afte	by F	1 ☐ Never Marri 3 ☐ Widowed		If Ye	res 2⊠ s, Give	No		1 □Yes	2 🔼 No	Specify	·:			Specif	fy:	D11-
hour tural		3 🖂 Widowed		nt's Education	or Dates:		16a. De	ecedent's Us	ual Occur	oation			16b.	Kind of B	lusiness/Ir	Black
iin 72 in "ne Teolic	plet		cify only highe	est grade comple		F)	(G	live kind of w fe. DO NOT	ork done	during mos	st of work	ing				·
d with giene ir tha	Completed	Elementary/Seco 12	ondary (U-12)	Colle	ege (1-4or	0+)		Entre	preneu	r				Tra	anspor	tation
al Hy othe	Be C	17. Father's Name	(First, Middle,	Last)						18. Moth	er's Nam	e (First, Middle	e, Maide	en Surnai	me)	
uld b Ments arked	To E		Ac	drianos R	oba							Terefe	ch G	ugesa		
2 sho and Is ma		19a. Informant's Na	ame/Relations	ship (Type. Print	)		19b. M	lailing Addre	ss (Street	and Numb	er or Ru	ral Route Num	ber, City	or Town	, State, Zi	ip Code)
and lealth m 27				- Sister								taskala,	_			
ges tof H of H ite		20a. Method of Dis	•	3 Removal	from State	20b. P	lace of Die emetery, o	isposition (Nation of the crematory or crema	ame of other plac	ce)		Date	20c.	Location	- City or I	own, State
t. Part trant: tant:		4 ☐ Donation	5 Other (S	Specify)		Gat	te of	Heaven				/2009	Si1	ver S	pring	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantical must be notified at once.		21. Signature of Fu	neral Service	Lidensele Mo	# for	70	F .	22. Name Hine:	s-Rina	ldi Fu	inera]	Home, I	nc			
0.0260		Vanc	7 17	Vec-			re							r Spr	ing, M	laryland 20904 Approximate
		23a. Part1. Enter t shock, or her Immediate Cause		t only one cause	on each I	ine.	L DO HOL	do -	ode or dyn	ng, such a	s cardiac	orrespiratory	arrest,			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	on	a	- 1 - /			6 IX	16							
Examiner					ie to (or as	a consequ	uerice oi):									
5,500	Jer	Sequentially list co if any, leading to im	nditions, nmediate	b	e to (or as	a consequ	uence of):	:								
executed n and ial-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events	injury s	C									_			
e exe ian al ırial-t	Ex	resulting in death)	Last	Du	e to (or as	a consequ	uence of):									
icate be executed physician and s the burial-transit	Jica			d												
leath certific attending p for use as	Physician/Medica	IF FEMALE:		220 If yo	out.com/	e of pregna	nov									
atten atten for us	ian	23b. Was deceden in the past 12	months?	1 🗆	Live birth	2   Fetal at time of d	l death	3 Ectopic		су					ate of deli Io <mark>n</mark> th	very Day Year
the de	ysic	1 □Yes 2[ 9 □ Unknown			Unknown	at time of d	icani	3 □ Other (	specny) _							
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the burn		Part II. Other signi	ficant conditi	ions contributing	to death I	out not resu	ulting in th	ne underlying	cause giv	en in Part	l.	23e. Did	tobacco	o use cor	ntribute to	the cause of death?
quires n sign	d by											1 🗆	Yes	2 No	3 ☐ Pro	obably 4 🗌 Unknown
sw rec	olete											24a. Wa		24b.	Were au	topsy findings available
The la	Completed											per	opsy formed? 2.21		death?	ompletion of cause of 2 □ No
sician: The law certificate has t irector, page 2 s	Be C	25. Was case refer examiner?	red to medica	ıl						26. Plac	e of Dea	th (Check only				
hysic his ce	70 E	1 Tes 2□	]No	Hospital:	1 🗌 Inpat	ient 2 🗆	ER/Outpa	atient 3 🗌 [	OOA Oth	er: 4 🗆 N	lursing H	ome 5 Re	sidence	6 🗆 01	ther (Spec	cify)
iding Physician: th. After this certifica funeral director, p	on:	<ol> <li>Manner of Deat</li> <li>Natural</li> </ol>	5 Pendi	na	Date of Inj (Month, D	ay, Year)	28b. Tim Inju	iry	28c. Inju Wor	k?		28d. Describe			_	•
ttend death tor: /	icati	2 Accident 3 Suicide	investi 6 ☐ Could	not be	9/23	•		own M		Yes 2	<b>X</b> /10	subject				
or At after of Direct in by	Certification:	4 ☐ Homicide	deterr			tc. (Specif	y) y)	, street, facto	огу, опісе							ral Route Number, Ind Place
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director, the funeral director director director director director, the funeral director		29a. Certifier (Check only		ng Physician: <sup>*</sup> I Examiner: On									ne cause	e(s) and r	nanner as	
the Hi hin 24 the Fi	Medical	one)		and	manner s		ttion and/c			se number	atii occu	Tred at the time				n, Day, Year)
<b>6</b>	-	29b. Signature and	Q	1 /	10-	1.	0-	2	i.L	The state of	(9	27	200. 1	aT s	10	1 78 7-6
		30. Name and addr	race of name	who cample	cause of	death /Ita-	22 a) /T:	no Print	145	105.	>/	-1	26	101-5		1, 200%
		Salva	ador	Sulv	2/1-		3000	3 /	spi	tal	1 1	rive	(	Cho	~~	le Ma.
Sta Registra	-	31. Date filed (Mon	P 30	2009	, negist	iai s Signa	400	while.								W.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar			,		Cer	tificate of l	Death		R	eg. No.			
			1. Decedent's Name (First, Mic	idle, La	st)							2. Date of Deat Month	h Day	Year	3.	Time of Death
	hysicia/ Medic/		. Allegaria	1	Marie A.	Reeve							nber 2	7, 2009		6:19 pm
	Examin		4a. Facility Name (If not institu	ion, giv	e street and nu	mber)	•		4b. City, Town, or	r Location	of Death		4c. Co	unty of Dea	th	
			17725 Tree	Lawn	Drive					Ashtor					tgom	
	uneral rector		5. Social Security Number <b>155-01-7622</b>	6. 5	ex □M 224 F	7. Age (In	yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under Hours		8. Date of Birth (Month, Day, November		Co	ountry)	(State or Foreign
pur	*		Usual Residence of Decedent  10a. State 10b. Cour	ntv		100	c. City, Town	orlo	cation						10d.	nside City Limits
e Maryla	8a-f sho	Director		ntgo	nery					Ashto	on					1 ∐Yes 2. KENo
h with th	23a or 2 ist be no		10e. Street and Number  17725 Tree	Lawn	Drive				10f. Zip Code	2086	L		Og. Citizer	of What Co	S.A.	
filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercinar must be notified at once.	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M	arried	12. Was Dece Armed Fo 1 ∐Yes If Yes, Gi	rces? 2 <b>⊠</b> No	in U.S.		Was Decedent of H f Yes, specify Cuba 1 □Yes 2⊠No			pecify Yes or No- Rican, etc.)		Race - Ame Black, Whit ecify:		ndian,
onus	Fal',	d by	3 X Widowed 4 ☐ Divord	ed	Year or D			<u></u>								ite
n 72 h	"natu	Completed	15. Deced (Specify only hig	hest gra	de completed)		16a.	(Give	dent's Usual Occup kind of work done DO NOT use retired	during mo	st of work		16b. Kind	of Business	/Indust	У
withii lene.	than	duc	Elementary/Secondary (0-12	2)	College (	1-4or 5+)			nistrative		tant		Nation	al Bure	au c	f Standards
filed v Hygid	other ent, I		17. Father's Name (First, Midd	le, Last	)				III DUI GULVO			e (First, Middle,				
ld be	ked c	To Be	J	osepl	L. Rodg	ers						Dorot	hy Bak	er		
shou nd M	mar	-	19a. Informant's Name/Relation				19b	. Mailir	ng Address (Street	and Numi	ber or Ru	ral Route Numbe	r, City or To	own, State,	Zip Co	de)
nd 2	27 is er trau		Patricia Cle	mens	- Daught	er		68	09 Woodston	e Pla	ce, Al	lexandria,	Virgi	nia 223	106	
s 1 a	othe		20a. Method of Disposition			2	20b. Place of	Dispo	sition (Name of matory or other place	ce)		Date	20c. Locat	tion - City or	Town,	State
rmit. Pages	int: If		1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 ☐ Other			State	Fort L		oln Cremato	1	09/3	0/2009	Brenty	wood, M	aryl	and
ermit.	Importa any inju once.		21. Signature of Funeral Servi	ce Lice	nsee	MO	1054	. Iπ-	2. Name and Addre	li Fund	eral I	Home, Inc.				
1 85 1	트뉴정		) Ola	1	Don	nel		1	1800 New Ha	mpshi	re Ave	enue, Silv		ing, Ma		
			23a. Part 1. Enter the disease shock, or heart failure.	or com	plications that one cause on o	caused the each line.	death. Do	not ent	er the mode of dyi	ng, such a	s cardiac	or respiratory are	rest,		Int	proximate erval Between set and Death
Phys	sícian		Immediate Cause (Final disease or condition		<b>3</b>		Kic	> N-E	g farm	re						3 years
	edical miner		resulting in death)		Due to	(or as a co	nsequence (	of):	1							
LXa	mmer	<u>.</u>	Sequentially list conditions,		b. Due to	(or as a co	onsequence (	of).							-	
ted	ısit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	⋞	Due to	(or as a co	risequence	017.								
rtificate be executed	ng physician and as the burial-transit	xar	that initiated events resulting in death) Last		c	(or as a co	nsequence	of):								
e pe e	siciar buri			l	d											
ificate	g phy is the	Medical			- u											-
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.		sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown			birth 2 ☐ ınant at tim	Fetal death		☐ Ectopic pregnand ☐ Other (specify) _	су			230	d. Date of de Month	elivery Da	y Year
that	ned b deta	y Phys	Part II. Other significant cond	litions	contributing to c	eath but no	ot resulting in	n the u	nderlying cause giv	ven in Parl	t I.	23e. Did to	bacco use	contribute	to the c	ause of death?
duires	n sign and bh	d by			Rhee	mako	TO AR	Xh	reh's			1 □ Y	es 2	No 3□ F	robabl	y 4 <b>⊠</b> Unknown
iclan: The law requires t	e has bee ge 2 shou	Completed			DIAG	EFES	s Me	lle-	fuj	_		24a. Was a autop perfor	sy med?	prior to death?	compl	findings available etion of cause of
	tificat or, pa	ပ္ပ	25. Was case referred to med	ical						26 Pla	ce of Dea	1 ☐ Yes		1 □Ye	s 2L	7100
sick	s cer direct	0	examiner? 1 ☐ Yes 2 🛣 No		Hospital:	Inpatient	2 □ ER/O	utpatie	nt 3 DOA Oth			lome 5 Resid		Other (Sp	ecify)	
_ E	ter thi	ü	27. Manner of Death		28a. Date	·	28b.	Time o		ırv at		28d. Describe h				
Attending Phy er death.	ir: Aff	atio	Z LI Accident	estigatio	n .	iiri, Day, re		11,019		Yes 2	□No					
al or Atte	I Directo	Certification: To	3 □ Suicide 6 □ Cou 4 □ Homicide det	ild not b ermined	28e. Place	e of Injury - ling, etc. (S	- At home, fa Specify)	ırm, stı	reet, factory, office			28f. Location (S City or Tow	Street and I vn, State)	Number or F	Rural R	oute Number,
e Hospita 124 hours	ie Funera	Medical C	29a. Certifier 1 Certi (Check only 2 Medi	fying P cal Exa	miner: On the	e best of m basis of ex nner stated	amination ar	e, deat	th occurred at the to	ime, date opinion, d	and place leath occu	e, and due to the urred at the time,	cause(s) a date and p	nd manner lace, and du	as state ue to th	ed. e cause(s)
To the within	To th comp	Me	29b. Signature and title of cer		Berry	Hee	25,00	Ð	29c. Licen	DIGI	90		•	signed (Mor	1	29 2005
_			30. Name and address of pers		completed cau	se of death	h (Item 23a)	(Type,	Print) 3941	FEAA	LARA	Druke	who	ENTER	ستو (	4D 20906
	Sta Registi		31. Date filed (Month, Day, Ye SEP 3 (	) 20	09 Ber	Registrar's	Signature	pa	Med							

09-07354 Victor Ramos Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 33087

	1- For State Registrar	C6	ertificate of	Death			Reg. No.	- 10	Time of Dooth		
Physician/ edical Examiner	Decedent's Name (First, Middle Victor	Manuel Ra	amos				per 20, 2009	ear	Time of Death 0202 hrs		
	4a. Facility Name (if not institution Georgia Avenue & Re		,	tb. City, Town, or L Silver Spring	ocation of Dea		4c. County Montgo	mery			
Funeral Director	5. Social Security Number 644-87-0987		last birthday)	If Under 1 Year Months Days	If Under 24H Hours M		/1959	9. Birthr Foreign Edoun	tS)alvador		
d how any		jomery Si	ty, Town or Locat	pring					0d. Inside City Limits  1 Yes 2 X No		
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number	la Avenue #30	4	10f. Zip Code 209	06		10g. Citizen of V				
r death with th or items 23a or must be notif	11. Marital Status 1 Never Married 2 XM	larried 12. Was Decedent Ever in Armed Forces?	U.S. 13. Wa	as Decedent of Hisp res, specify Cuban, Yes 2 No	Mexican, Pue	Specify Yes or nto Rican, etc.) /adoral	Wh	hite, etc. hite	an Indian, Black,		
2 hours afte "natural"; [Examinet	4 Dividowed 4 Div	vorced If Yes, Give Year or Dates: cify only highest grade completed) College (1-4 or 5+)	16a Decede	nt's Usual Occupationst of working life.	on (Give kind	of work done	16b. Kind of	16b. Kind of Business/Industry  Landscape			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medic	unknown				Conce	ocion 1			7:- 0:-(1)		
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Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra	20a. Method of Disposition  1 XBurial 2 Crematic  4 Departion 5 Other S	Sal	vador								
Balti permit. Departi Import injury	1 XBurial 2 Cremation 3 X Removal from State Municipal Cemetery 10/03/2009 El Salv 4 Donation 5 Other Specify: 21. Sure of Funeral Service Licensae 7 29 Name and Podress of Actival DI FUNERAL SERVICE 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										
Physician Medical taminer	23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on each line.		the mode of dying,	such as cardia	ac or respiratory	arrest, shook, or	nou.t	Approximate Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		ce of):								
outed nd transit	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last		ce of):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U  Part II. Other significant cond	4 Pregnant at time of	2 _ 1	Fetal death 3 Other (Specify)	Ectopic pro	egnancy	23d. Dat Mont	e of delivery	Day Year		
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Vital Recysician: The linis certificate director, page		cal		26.Plac	e of Death (Ch	neck only one)					
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Division of N Division of N within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	(Check only one) 2 Medical E	Physician: To the best of my kno xaminer: On the basis of examinat and manner stated.	wledge, death oc	gation, in my opinio	n, death occu	e, and due to the rred at the time,	date and place, a	and due to t	ne cause(s)		
2	29b. Signature and title of cer	ijiler			S.M.E.		i i	ber 20,			
OCME	30. Name and address of personal Mary G. Ripple MD.	son who completed cause of death Deputy Chief Medical I	(Item 23a) Examiner	111 Penn Stree	et, Baltimor	re, MD 2120	)1				
Sta Registi		2009 Registrar's Si	gnature 400	wed							

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	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
	/Medic		TAHEREH RAZAVI				Septemb	er 19, 09	
	Examin	er	4a. Facility Name (If not institution, give street and number	")		Location of Death		4c. County of I	
N.b.	F		Hebrew Home  5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	Rockvil If Under 1 Year	LE If Under 24 Hrs.	8. Date of Birth (Month, Day	Montgon	Birthplace (State or Foreign
	Funeral Director		220-45-2102 1□M 2€F	91 Yrs.	Months Days	Hours Min.	(Month, Day 1/1/18	( Year)	Country) Iran
	pe ,		Usual Residence of Decedent						
	arylar show	ž	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 【XNo
	the M	ecto	MD Montgomery  10e. Street and Number	Rockville	10f. Zip Code			l 0g. Citizen of Wha	
	with yar	ij	6 Foxden Court		20850		'	USA	a oddiniy:
	ms 2%	Funeral Director	11 Mas Deceden	t Ever in U.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-		American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It is Medical Examinar must be notified at once.	by	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates	No	f Yes, specify Cuba I □Yes 2 🏅 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	White, etc. Iranian
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21	ithin ne.	)du	Elementary/Secondary (0-12) College (1-4or	5+)	kind of work done o	i)	9		
5	iled w Hygie ther t		12 17. Father's Name (First, Middle, Last)	Homen	naker	18 Mother's Nam	e (First Middle	Home  Maiden Surname)	
au	d be f ental ced o	To Be	Sayed Alireza			Soghra I	•	maraon ournamo,	
ar y	shoul and M marl	F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street			r, City or Town, Sta	ate, Zip Code)
ž	is 1 and 2 and 1 and 2 and 1 a		Simin Roshan - daughter	6 Fox	kden Cour	t, Rockv:	ille, MD	20850	
Ore	es 1 a of He of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	re)	Date	20c. Location - Cit	y or Town, State
Ĕ	Pages ment of I	8	4 Donation 5 Other (Specify)	/   Gate/ of H				Silver Sp	
Baltimore, Maryland	Departi Departi Importi any Inj once.		21. Signature of Funeral Service License	4 4 1				neral Hom ville, MI	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. Ust only one cause on each	ed the death. Do not ent line.	er the mode of dyin	ig, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
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Records,	quires n sigr ıld be	d by					1 □ Y	es 2 <b>X</b> No 3[	☐ Probably 4 ☐ Unknown
00	sw requir s been s should l	olete					24a. Was a		re autopsy findings available
ž	The lav	Completed					autop: perfor 1 🗆 Yes	med? dea	or to completion of cause of ath? IYes 2 XNo
Vital	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only or		22410
of <	ding Physician: The In. After this certificate he funeral director, page		1 Yes 2 No Hospital: 1 Inpa	tient 2 ER/Outpatier		4 LXNursing H	ome 5 ☐ Resid	ence 6 Other	(Specify)
ň	Ilng F	ion:	27. Manner of Death 1 Natural 5 Pending 28a. Date of In (Month, E	jury 28b. Time of lay, Year) Injury	Worl		28d. Describe h	ow injury occurred	
isi	Attend ar death ector: , by the f	icat	2 ☐Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place of It	piury - At home form etr		Yes 2 ☐No	28f Location /C	troot and Number	or Rural Route Number,
Division	I or Atten after deat Director: I in by the	Certification: To	determined 200. Flace of II	njury - At home, farm, stro etc. <i>(Specify)</i>	eer, ractory, onice		City or Tow	n, State)	or nural noute Number,
-	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, is	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the basis and manner sand mann	of examination and/or in	n occurred at the til vestigation, in my o	me, date and place pinion, death occu	e, and due to the or rred at the time, or	cause(s) and manr date and place, and	ner as stated.  d due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of dertifler	0	29c. Licens	e number		29d. Date signed (/	Month, Day, Year)
			Banklan Kal	re they W	1 <i>)</i>   <sub>D3543</sub>	6		9/19/09	
	•		30. Name and address of person who completed cause of	death (Item 23a) (Type,		U		3/ 13/ 03	
			Barbara Kalazny 6121 Mon	trose Road,		e, MD 20	852		
	Sta Registr		31. Date filed (Month, Day, Year) 32 Aegis OCT 01 2009	trar's Signature	a Kal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per phys. G897 11/30/09 dk
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) **Physician** Nicholson 4:02 P M Nancy Rainey September 28, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) 05/28/1946 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 63 Pennsylvania 156-36-4654 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, Ire Modical Examinar mast be notfiled at 1 □Yes 2□No Director Maryland Montgomery Germantown 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 20874 United States 4 Duhart Court Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2X No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) n and Mental Hygiene. College (1-4or 5+) Hair Dresser Beauty Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie Conrad Elmer Nicholson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Pages 1 and 2 4 Duhart Court - Germantown, MD. 20874 Husband Edward T. Brown, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept.29 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 2009 4 □ Donation 5 □ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Lice Devol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877 Part 1. Enter the dis so, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cau (Final hease or indition resulting in death) SHO( **Physician** /Medical Due to ( as a consequence of): Examiner NE UMOI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 DUnknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The 2 No 1 TYes 1 ☐Yes 2 🖾 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. To the l within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville

State Registrar

Zhana

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Medical

State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#7perFH, 10-1-09, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 28, 2009 **Physician** Edith Rosenberg 4:46a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth O 1/24/1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🛛 F 81 Germany Director 200-30-4401 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D. partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, if the Maryland of the page 1 and 1 an 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 No Director Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6121 Montrose Rd. 20852 US Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ I If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 unk" 1 ☐Yes 2X No Specify. Specify: White à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College/Education Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Theodor Rosenber Be Rosenberg Banet Rela ည 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephanie Fink/ Attorney 600a Monroe St. Rockville, Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 10/01/09 Olney, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Danzansky Goldberg 1170 Rockville Pike Rockville, Md. 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after neath use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): ろんれ タル Box 68760, Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MELLITUS 3 Probably 4 Unknown 1 ☐ Yes 2 DINO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner: 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) we Rel .6121 UD. 31. Date filed (Month, Day, Registrar's Signature State Registrar

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		1 - For State Registrar		yland / De <sub>l</sub>	partment of H ertificate of L	ealth and N	Mental Hygi	_	33091
Diam'r.		1. Decedent's Name (First, Middle, Last)					Date of Death     Month		3. Time of Death
Physicia /Medic		Caroline Rachel	Romine				Septembe	r 22, 2009	12:13 P M
Examin		4a. Facility Name (If not institution, give street	et and number)			Location of Death		4c. County of Death	
<i>l</i>		Shady Grove Hospital			Rockvil]			Montgomer	
Funeral Director		5. Social Security Number 212-60-4086  Usual Residence of Decedent  6. Sex 1 □ M		(In yrs. last birthda 61 Yrs.	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 8,	Year) 9. Birth Cou 1948 Ind	place (State or Foreign intry) iana
and and		10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
Maryl f sho	ō	Maryland Montgomery		Gaither	sburg				1⊠Yes 2□No
the 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
3a ol		105 N. Summit Ave. A	pt. 3		20877			United St	ates
death ms 2	by Funeral	11 Marital Status 12. V	Was Decedent Ev	er in U.S.	3. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
after or ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 X No fYes, Give		1 ☐Yes 2X No	Specify:	nicali, etc.)	Black, White	
ours Iral",	d b	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:						nite
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vithin ene. than	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		al Assista		·	Nuclear Reg Commission	gulacory
be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Marical Examinar must be notified.	ပ္သ	17. Father's Name (First, Middle, Last)		J1 108	,41 71351504		e (First, Middle, M		
d be ental ked o	To Be	Woodward Romine						Banghart	
shoul nd M marl	Ĕ	19a, Informant's Name/Relationship (Type. I	Print)	19b. Ma	ailing Address (Street a	and Number or Ru	ral Route Number,	City or Town, State, Z	ip Code)
nd 2 alth a 27 is		Rebecca E. Fenton/Da	ughter	5949	Laurel St	reet; Ne	w Orleans	s, LA 70115	5
s 1 a	ĺ	20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place	e)	Date 2	Oc. Location - City or T	own, State
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		23a. Part 1. Enjer the disease, or complication shock of heart failure. List only one ca	ons that caused th	ne death. Do not	enter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Roma	l Fai	luce				Onset and Death
/Medical		resulting in death)	Due to (or as a	consequence of):	0				^
Examiner		Sequentially list conditions. b. —	seps	is Syn	drome				pays
ed sit	ine	cause. Elizar proderlying	Due to (or the air	nonsequanneibf)					
xecut and Il-tran	Examiner	Sequentially list conditions, if any, but in the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
te be executed ysician and e burial-transit	calE			,					
ficate phy:		d							
Attending Physician: The law requires that the death certifica rodath.  ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Med		If yes, outcome of					23d. Date of deli	very
death e atte d for	icia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pregnancy 5 ☐ Other <i>(specify)</i>	<u> </u>		Month	Day Year
t the by th	hys	9 Unknown	9 ☐ Unknown						
ss tha gned	by P	Part II. Other significant conditions contribute	uting to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	
equire en si ould k	ed	rancytofenso,	HIFAM	4			1 ☐ Ye	s 2 <mark>/00</mark> No 3 □ Pro	obably 4 Unknown
law ra as be 2 sh	Completed						24a. Was an		topsy findings available completion of cause of
The ate h	lo l						perform	ed? death?	2 🗆 No
clan: ertific ector,	Be (	25. Was case referred to medical examiner?					th (Check only one	2)	
Physic this cal dire		1 ☐ Yes 2 No Hosp	1 Inpatient	2 ER/Outpat		4 LI Nursing H		nce 6 Other (Spec	cify)
ding l	ioi	1 Natural 5 ☐ Pending	8a. Date of Injury? (Month, Day,	Year) 28b. Time Injur	y Work	yat :? Yes 2 □No	28d. Describe how	w injury occurred	
death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	8e Place of Injury	/ - At home farm	street, factory, office	Yes Z LINO	28f Location (Str	eet and Number or Ru	ral Route Number
or A after Direction by	Certification: To	4 ☐ Homicide determined	building, etc.	(Specify)	on out, lability, office		City or Town,		141 710010 712111001,
spita nours neral		29a. Certifier 12 Certifying Physicia							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examiner: one)		examination and/or					
To th withir To th comp	Me	29b. Signature and title of certifier	7 /	7	29c. License	e number	29	Date signed (Month	n, Day, Year)
10		Hos of Ch	reall	2	294	153	1	reprember	22,2009
		30. Name and address of person who compl	eted cause of dea	ath (Item 23a) (Typ	pe, Print)			1.	
		Alan Chanale	5-152	25 5	hady Gra	ove Rd.	, # 205T	Rockuille	22, 2009 22, 2009 21, Md. 2085
Sta		31. Date filed (Month, Day, Year)	Registrar'	s Signature	a Kall				-
Registr	ar	001 01 2009	Kentur	14. 140	A PARTY				

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			epartment of Health and Ce <i>rtificate of Death</i>		ene 2009 33092
Physic		1. Decedent's Name (First, Middle, Last)  Maxine Loraine REICHERT		2. Date of Death	3. Time of Death
Med Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
		Washington County Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthdom)	Hagerstown  If Under 1 Year   If Under 24 Hr	S. 8. Date of Birth	Washington
Funera Directo		220-28-3394 1 □ M 2 🖾 F 76 Y	Months Days Hours Mir		9. Birthplace (State or Foreign Country) 1933 Maryland
and show	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location		10d. Inside City Limits
Maryl 28a-f otifie	irec		gerstown		1 🌠 Yes 2 □ No
ith the 23a or st be r	Funeral Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
eath w tems :	Fune	320 Valley Road  11. Mantal Status 12. Was Decedent Ever in U.S.	21742  13. Was Decedent of Hispanic Origin? (	Specify Yes or No-	USA 14. Race - American Indian,
'e-, Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	ted by	1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 🏋 No Specify:	rto Hican, etc.)	Black, White, etc.  Specify: White
72 hou	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of w fe. DO NOT use retired)	orking 16	6b. Kind of Business Industry
212 within giene.	S	8 College (1-4 or 5+)	Homemaker		Her own home
and oe filed ortal Hy ced off	To Be	17. Father's Name (First, Middle, Last)  Max Bowers		ame (First, Middle, Mai	,
aryl			Mailing Address (Street and Number or F	Mae Monde	
nd 2 sh ealth a m 27 is		Bobby Lee Reichert - Husband 32	O Valley Road, Hag		
imore Page 1 au nent of H ant: If iteu		1 Burial 2 X Cremation 3 Removal from State cemetery,	Disposition (Name of crematory or other place)		Oc. Location - City or Town, State
Baltimore, N permit. Page 1 and 2 Department of Health Important If item 27 any injury or other to		4 ☐ Donation 5 ☐ Other (Specify) Hagers  21. Signature of Funeral Service Licensee	town Crematory 10/ 22. Name and Address of Facility		agerstown, Maryland
Balti permit. Departri Imports any inju		Palent Blankin			neral Home own, Maryland 21740
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Arteriosaler		ac or respiratory arrest,	
Medica Examine		resulting in death)  Due to (or as a consequence of)			
ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury			
760 cate be executed physician and sthe burial-transit	al Exa	that initiated events c.  The property of the			
	ledical	d			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3		23d. Date of delivery Month Day Year
P.C s that 1 gned b	è	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds, equire	eted	Emphysema Emphysema			2 No 3 Probably 4 Unknown
fital Reco sician: The law i certificate has t irector, page 2 s	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2  No
/ital /sician s certifi director	To Be	25. Was case referred to medical examiner?  1 \( \text{A} \) Yes 2 \( \text{No} \) No  Hospital:  1 \( \text{X} \) Inpatient 2 \( \text{ER/Outp.} \)	26. Place of Death (Ch		- C - Other (O//)
Ing Phy I. After this		27. Manner of Death  1   Natural 5 □ Pending  28a. Date of injury (Month, Day, Year) injury injury (Month, Day, Year)	ne of 28c. Injury at work?	28d. Describe how	e 6 Other (Specify) injury occurred
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  In Director, After this certificate has been signed in by the funeral director, page 2 should by	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No , street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, state)
Le Hospita n 24 hours ne Funeral	Medical	29a. Certifier (Check (Check only one)  1 □ Certifying Physician: To the best of my knowledge, de control of the control of t	nvestigation, in my opinion, death occurred	d at the time, date and p	place, and due to the cause(s) and manner stated.
To the withing to the complete		29b. Signature and title of certifier	29c. License number 70 - 1062	29d	Date signed (Month, Day, Year)  Dec. 3, 2009
SH-2		30. Name and address of person who completed cause of death (Item 23a) (Ty Edward W. Sitto, III MD 19011 Or	pe, Print)	. Hagersto	own, MD, 21742
St Regist	ate rar	31. Date filed (Month, Day, Year) 6 2009 32. Pigistrar's Signature	ford	.,	

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		tificate of Death	R	eg. No.	30095
	Physici		1. Decedent's Name (First, Middle, Last)  Hattie Mildred Reed			2. Date of Deat  Month Septemb	er 22, 2009	3. Time of Death 9:13 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
, 			1613 Burris Road		Rockville		Montgome	2
	Funeral Director		219-48-4379 1□M 2図F	94 Yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Dec. 17	Year) 9. Birth Cou.	place (State or Foreign intry) ginia
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	e Mary	ctor	Maryland Montgomery	Rocky	ville			1. Yes 2 □ No
	th with th 23a or 26	Funeral Director	10e. Street and Number 1613 Burris Road		10f. Zip Code 20851		Og. Citizen of What Cou nited State	*
036	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23e or 28e-f show event, it a Moulcel Examination cofficial at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 ※ N If Yes, Give Ye ar or Dates:	io	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert ☐Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White, Specify: Wh	etc.
9200-612	filed within 72 ho Hygiene. Other than "natur ent, tre Medicel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-	(Give I	ent's Usual Occupation kind of work done during most of wor OO NOT use retired)	king	16b. Kind of Business/II	ndustry
7	ed witl lygiene ner tha	Con	(unk.)	Home	emaker		Own Home	1-
	should be fill nd Mental H marked oth	To Be	17. Father's Name (First, Middle, Last) (unk.)		18. Mother's Nan	ne (First, Middle, M	Maiden Surname) (UI	ik.)
Mar)	d 2 sho th and I 7 Is ma trauma		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and Number or Ru			ip Code)
<u>စ</u> ်	s 1 and of Heal item 2 other		Robert Anger / Grandson  20a. Method of Disposition	20b. Place of Dispos	Burris Road, Rock		20c. Location - City or T	own, State
saltimore,	Page ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Comer (Specify)	Resth Memorial	laven Gardens 2		Frederick,	Maryland
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of uneral Service Livinsee	Re 95	Name and Address of Facility sthaven Funeral S 01 Catoctin Mtn.	Services,	Skkot Cody	y P.A. 21701
			23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each lin-	the death. Do not ente				Approximate Interval Between
F	hysician /Medical		resulting in death)	Failure				Onset and Death
/	Examiner		Buro-teo	a consequence of):				Unknown
	nsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	nonsequence of/c				
Ď,	rificate be executed ng physician and as the burial-transit	Еха	that initiated events resulting in death) Last C. Due to (or as a	a consequence of):				
68760,	Tiricate b ng physic as the bi	Medical	d					
	ung rnystotan: The law requires that the death certi h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of the birth 2 in the birth 2 in the birth 3 in the past 12 months? 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delive Month	very Day Year
Л	res tnat signed by be deta	by P	Part II. Other significant conditions contributing to death bu	it not resulting in the un	derlying cause given in Part I.		bacco use contribute to	
ecords,	v requi	eted	TRINIA	····		1 ☐ Ye		bably 4 Unknown
ב ת	r: Ine rav ficate has r, page 2	Completed				autops perforn	y prior to comed? death?	opsy findings available ompletion of cause of
VITAL	sicial s certii irecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatier		Other	th (Check only on		
0	ig rny ter this neral d	$\vdash$	27. Manner of Death 28a. Date of Injur	nt 2 ER/Outpatient  y 28b. Time of Injury	28c. Injury at Work?		ence 6 Other (Spec ow injury occurred	ity)
VISION	trending death. tor: At the fur	icatic	2 Accident investigation		M 1 □Yes 2 No			
2	ital or A irs after ( ral Direc led in by	Certification:	4 Homicide determined 20e. Flace of Injurial building, etc.			City or Towr		
	ro the hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier  (Check only one)  CertifyIng Physician: To the best of and manner state.	examination and/or inv	occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
,		¥	29b. Signature and title of certifier	(00)	29c. License number	2	9d. Date signed (Month	, Day, Year)
	100		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	Print)	Ste 3	5. 1 24/09	
			Amor V. Duggiralas I	D.O. 19	110 Fisher A	ene,	100 Louil	1c, md
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	cike	t		20837

			For State Registrar	State	of Maryl	and / Depa	irtment of <i>tificate o</i>				giene Reg. No.	115	83094
			Decedent's Name (First, Middle, La	ast)						2. Date of Dea	ath	-	3. Time of Death
	Physicia /Medic		BESSIE	Μ.		REED				Month SEPTEMI	BER 28	Ye ar 2009	7:05A M
	Examin		4a. Facility Name (If not institution, gi	ve street and nu	umber)		4b. City, Town	, or Location	of Death		4c. Cou	nty of Death	
and the			513 DRUM AVENUE				CAPITO						ORGE 'S
	Funeral Director		5. Social Security Number 169-30-0866	Sex 1☐ M 2X F	7. Age (In:	yrs. last birthday) Yrs.	If Under 1 Year Months Day		r 24 Hrs. Min.	8. Date of Birt (Month, Day MAY 25		Cou	place (State or Foreign ntry) NSYLVANIA
	w w		Usual Residence of Decedent  10a. State 10b. County		10c	. City, Town or Lo	cation					1	10d. Inside City Limits
	f show	ō		CEODCE				C					1 XYes 2 No
	the 1	Director	MD PRINCE  10e. Street and Number	GEORGE '	5	CAPITOL	10f. Zip Code				10g. Citizen	of What Cou	ntry?
	h with	al D	513 DRUM AVENUE	Ξ			2074	3			USA		
	ems a	Funeral	11. Marital Status	12. Was Dec		n U.S. 13. \	Was Decedent of	f Hispanic O	rigin? (Span, Puerto	ecify Yes or No- Rican, etc.)	- 14. F	Race - Ameri	
20	be filed within 72 hours after death with the Maryland Hyglene. d other than "natural", or items 23a or 28a-f show event, I'm hadden Everning." or items 24 or 18	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ∐ Yes If Yes, G Year or [	2 No live X		I⊡Yes 2DM				Spe		LACK
3	tural	ed t	15. Decedent's 8		Dates.	16a. Deced	dent's Usual Occ	upation			16b. Kind of	f Business/In	dustry
2	hin 72 e. an "ne	plet	(Specify only highest gastering (Specify only highest gastering) Elementary/Secondary (0-12)	rade completed)	) (1-4or 5+)	`life. L	kind of work don DO NOT use ret	ired)	st of worki	ing	COM	TO NIMITAN	Tr.
V	ygien ygien ier th	Completed	12TH		(, , , , , , , , , , , , , , , , , , ,	BUDO	GET ANAI					ERNMEN'	<u> </u>
2	ges 1 and 2 should be filed within 72 hours after death with the Maryla tr of Heath and Martal Hyglier and the Azi is marked other than "natural", or items 23a or 28a-f should filem 27 is marked other than "natural", or items 23a or 28a-f should remark to event, I to had only a content traumatic event, I to had only a content traumatic event, I to had only a content to the content traumatic event, I to had only a content to the content t	o Be	17. Father's Name (First, Middle, Las JOHN CALVIN MEAD	•						(First, Middle, C.M. SIM		name)	
<u> </u>	shoul ind M i mark	으	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Stre	et and Numl	ber or Run	al Route Numbe	er, City or To	wn, State, Zij	c Code)
, M	and 2 salth a r 27 is		CHRYSTAL MEADOWS	/DAUGHT	ER	513 1	DRUM AVI	ENUE C	APITO	L HEIGH	ITS,MAI	RYLAND	20743
ב ב	of He of He fitem		20a. Method of Disposition  1	T Romaval from	State 20	b. Place of Dispo cemetery, cren	sition (Name of natory or other p	olace)	[	Date	20c. Location	on - City or To	own, State
	: Pag tment tant: I jury c	- 0	4 ☐ Donation 5 ☐ Other (Spec	eify)		RESURREC'					CLINTO		
ם	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Fun al Service Lice	ensee			Name and Add			. B. JEN LANDOVI			L HOME 20785
ř			23a. Part 1. Enter the disease, or cor shock, or heart failure. List onl	nplications that	caused the	death. Do not ent	er the mode of	dying, such a	ıs cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-		ASCULAR I	DISEASE					1	Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a con	sequence of):						i	
	Cxanime	<u>.</u>	Sequentially list conditions,	D.		IVE HEAR	T FAILU	RE					
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		PERTE	· ·							
,	execun and ial-tra	Ехаг	that initiated events resulting in death) Last	C		sequence of):							
00,00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical		AN	NEMIA								
Š	ding p	/Med	IF FEMALE:	23c. If yes, or	utcome of pr	agnancy					00.1	D	
ם	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	birth 2   gnant at time	Fetal death 3	Ectopic pregna Other (specify				230.	Date of deliv Month	Day Year
į	t the d by the ached	hysi	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	9 □ Unk									
'n	ss that gned l	by P	Part II. Other significant conditions	contributing to	death but not	t resulting in the u	nderlying cause	given in Part	H.				the cause of death?
200	equire sen si ould b	ted	ATRIALF	IBRTLLAT	LION					1 🗆 1	Yes 2.1XIN	o 3□ Pro	bably 4 🗌 Unknown
ב	law r has be e 2 sh	Completed	RHEUMATO	OID ARTI	HRITIS					24a. Was autop	osy	prior to co	opsy findings available ompletion of cause of
ם ב	n: The licate r, pag			1						1 □ Yes		death? 1 ☐ Yes	2√□No
7	siciar certif	Be c	25. Was case referred to medical examiner?	Hospital:	7 to a set a set	2 T FD/0tti	4 20004	Othor		h (Check only o		Oth - : / / / / . :	
5	g Phy er this eral d	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date	e of Injury	2 ER/Outpatier	28c. li	njury at	Nursing Ho	me 5 🔀 Residence 1			ny)
5	ath. rr: Aft	atio	1 Natural 5 Pending 2 Accident investigation	on	nth, Day, Yea	ar) Injury		Vork? □Yes 2[	□No				
2	or Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not determine	a Zoe. Plac	e of Injury - ding, etc. (S)	At home, farm, str pecify)	eet, factory, office	ce		28f. Location (8 City or Tox		ımber or Rur	al Route Number,
_	spital ours a neral (		29a. Certifier 1 X Certifying F	hysician: To th	ne best of my	/ knowledge, deat	h occurred at th	e time, date :	and place,	and due to the	cause(s) and	d manner as	stated.
	he Ho in 24 h he Fui pletely	edical	(Check only 2 ☐ Medical Exa one)		basis of exa nner stated.	mination and/or in	vestigation, in n	ny opinion, de	eath occur	red at the time,	date and pla	ce, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0 1	110	20		ense number 5766	r		29d. Date sig		Day, Year)
	m		30. Name and address of person who	o completed	uso of dooth	(Itam 23a) /Tura							
A	2		SAMUEL W. ALLEYI	NE M.D.	6005	LANDOVER		HEVERL	Υ, Μ	ARYLAND	2078	5	
I	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 1 2009	Esca	Registrar's S	Signature							
					*								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 26, 2009 **Physician** 0116 ROBINSON WAYNE C. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE PRINCE GEORGE HOSPITAL CHEVERLY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT • 12, 9. Birthplace (State or Foreign 5. Social Security Number Sex 1 M 2 □ F **Funeral** Ĩ941 VIRGINIA 67 224-54-4486 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Machael Examinar, part the notified at once. 1√2 Yes 2 No Director BRENTWOOD MD PRINCE GEORGE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20722 3723 38th AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🛣 No Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE MAINTENANCE 9th 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be ELIZABETH BUSHROD LATTIMORE ROBINSON ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 38th AVENUE BRENTWOOD, MD 20722 ELIZABETH ROBINSON/WIFE 3723 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MT. MORRIS BAPT CHURCH10-03-2009 HUME, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** /Medical Due to (or as a consequence of) Examiner ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed CRONARY burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4 Pregnant et time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by the should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2. autopsy performe 2 No 1 ☐Yes 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or/investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. Medical within 24 hor To the Fune completely fi Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death item 23a) (Type, Print) CAREENBELT, MD 20170 SINGH, MD 1319A HANOVER 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible ink, Ensure All Copies Are Legible. amend item 5 per inf g908 10-19-10 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2103 M Der 26,200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 5. Social Security Number 43 If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days **Funeral** Months 1 M 2 X APRIL MASS. 1966 43 5 Director 595-05-<del>9340</del> Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County show 10a. State be notified at 1 X Yes 2 ☐ No Director HOWARD **JESSUP** 28a-f MD10g. Citizen of What Country? 10e. Street and Number 10f Zin-Code ö USA 20794 8839 WILLOWWOOD WAY Funeral Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 TNo Specify. Specify:BLACK þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the ACCT. MANAGER PRIVATE 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARIE THOMAS CLIFFORD REYNOLDS JR. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ant: If item 27 is r CHERYL THOMAS/SISTER 8839 WILLOWWOOD WAY JESSUP, MARYLAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ( 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Donation 5 Other (Specify) HOLY CROSS CEMETERY 10-3-2009 PENSACOLA, FLORIDA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest vist only one cause on each line.  $I_-$ Approximate Interval Between 23a. Part 1. Enter the diseas shock, or heart failure. Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 NO Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Inpatient 2 No 2 ER/Outpatient 3 DOA Medical Certification: To eral Director: After this filled in by the funeral d 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 Accident 3 Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 ADHIKARI 600 North Wolfe St, Baltimore, MD, 21287 DHOI 32. Registrar's ignatu

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra/AMEND#23eperMD, 10-5-09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year  $P_{\mathsf{M}}$ **Physician** 25,2009 September Roland Sneed /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1₩ M 2□ F Months Days Yrs. April 29,1936 North Carolina Director 241-44-8588 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantina crust be notified at 10a. State 1√2Yes 2 No Directo Maryland | St. Mary Charlotte Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20622 United States 29449 Charlotte Hall Road Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 QYes 2 No
If Yes, Give 1959 1961 Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Black Completed by 3 2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Program Specialist Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eloise Williams Roland H. Sneed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) int of Health at: If Item 27 is 4320 Oxford Drive Camp Springs, Maryland 20746 Kwasi Sneed/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 10/03/2009 4 ☐ Donation / 5 ☐ Other (Specify) Ft. Lincoln Brentwood Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. Signature of Funeral Service Licenses 7400 Georgia Avenue, NW Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION **Physician** PHEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACCIDENT CARDIO VASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine HYPERTENSION ESSENTIAL physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown LEROTIC CARDIOVASCULAR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has I irector, page 2 s autopsy perform 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2∐LNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, I hours after death.

Uneral Director: Af

Baltimore, Maryland 21215-0036

within 24 hours after
To the Funeral Dire
Completely filled in b Medical To the

29a. Certifier

(Check only

29b. Signature and title of cerlifier MD 29c. License number

D67788

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 28

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

RAO KODALI 14090 HG Trueman Road, Solomons, MD 20678 31. Date filed (Mo)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 27, Month **Physician** September 2009 6:10 p M Rosemarie Scalco /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hillhaven Nursing Center, Inc. Adelphi | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 25, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M Washington, DC 578-32-6333 84 1925 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County init. Pages 1 and 2 should be filed within 72 hours after death with the Marylar ardment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Adelphi 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3210 Powder Mill Road 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 本文No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within in and Mental Hygiene.
7 is marked other than "i Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominic Salvanelli Jennie Morisi ပ 19a. Informant's Name/Relationship (Type. Print)
Salvatore Richard Scalco/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16704 Gooseneck Terrace, Olney, MD 20832 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 2009 permit. Page Department of Important: If any injury or Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or conshock, or heart failure. List on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine dute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🕱 No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknow signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting the underlying cause given in Part I. δ 2 NO 1 Yes 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 Marsing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 ☐ Pending investigation 2 Accident

P.O. Box 68760 Records, Division or Vital To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is

Maryland 21215-0036

Baltimore,

29a. Certifier

3 ☐ Suicide

4 Homicide

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Medical

Registrar's Signature 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William Lewis SAFIRE September 27, 2009 **Physician** 10:48 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 17 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1929 New York Days Hours 79 103-22-7703 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "redical Experiment", until by notified at 1 Yes 2 □ No Director Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with I h and Mental Hygiene. 'Is marked other than "natural", or Items 23a or 3 United States 20815 6200 Elmwood Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married white Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: 52-54 Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) New York Times Journalist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Panish Oliver Safir ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Gode) 2 Hastings - On - Hudson, NY 10706 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 & Department of Health al Important: If item 27 Is any Injury or other trau. Mark Safire, Son Baltimore, 09/30/09 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3 🛱 Removal from State King David Memorial Garden Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee MOIDDS TOrchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown icate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \cancel{N}$  Other (Specify)  $\cancel{Hospice}$ 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 27, 2009 J. Kouatchou, D63748 +1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855 31. Date filed (Month, Day, Year) -32 Registrar's Signature park 30 Registrar

/Medic	an	1. Decedent's Name (First, Middle	110.00.	ind St	einscl	hneide	er			2. Date of Dea	Day 25	Year	3. Time of Death 10:10 a <sub>N</sub>
		4a. Facility Name (If not institution			Desc	4h City	Town or	Location of	of Death	SEPT		County of Death	
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ineral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under	1 Year	If Under		8. Date of Birt (Month, Day	h Voor)	9. Birth	place (State or Foreign
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2311		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							10d. Inside City Limit
Examiner must be notified at	ō			1007 010,									1 ☐ Yes 2 ☑ N
notif	rec	Maryland Mor 10e. Street and Number	ntgomery			10f. Zip		Rockvi	lle		10g. Citize	en of What Cou	ntry?
즼	<u>e</u>	10700 Kings Rid	ing Way, Apt.	. #101				2085	2			U.S.	Α.
Ē	Funeral Director	11. Marital Status		dent Ever in U.S	. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14	4. Race - Amer	
E STATE	by Fu	1 ☐ Never Married 2 ☒ Marr		2 🔀 No		1 ☐ Yes 2		Specify:		Triodii, cio.,		Black, White, Specify:	etc.
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IIC e	To	1	Max Glassman							Sophie	Borid	in	
anma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Run	al Route Numbe	er, City or	Town, State, Zi	p Code)
her tr	Į.	Alfred Steinschne	ider - Spouse										and 20852
or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from S	State 20b. Pla	ace of Dispo metery, crer	sition (Nam natory or ot	ne of ther place	e) !		Date	20c. Loca	ation - City or T	own, State
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any injury or other traumatic event, the Medical once.		21. Sign at re of veral Service	7	MO04	A H	2. Name and ines-Ri	inald	i Fune	ral H	lome, Inc.			
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	ļ	shock, or heart failure. List	only one dause on ea	ich line.		,				or respiratory ar	1651,		Approximate Interval Between Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year SARAH MARIAH SEWELL 24, 2009 <u>September</u> 7:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Ednor Elderly Home Care Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Hours 1 M 2 XF Director 217-32-6804 79 3/30/30 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 1 Yes No Director MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9425 Curran Drive 20901 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Yes. Give 2 Specify. Black 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Emma Jackson Unknown ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Dimes — friend <u>12029 Old Columbia Pike, Silver Spring, MD 20904</u> 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent | Crematory 9/29/09 Hanover, MD 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Snowden Funeral Home ₹246 N. Washington St, Rockville, MD 20850 eu 23a. Part 1. Enter the disease, ir complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Acute myocardial infarction hrs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in the land of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 📉 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a ca 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3720 Farragut Ave,

32. Registrar's Signature

Barry Rosenbaum

31. Date filed (Month, Day, Year)

D09834

Kensington, MD 20895

9/28/09

			For State Registrar	State of	Marylan	-	artmen rtificate			and M	F	gienė [] Reg. No.	U9	33	10:	?
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	/Medic	ai		ephine San			4h Cih	Town or	Location o	of Death	Septem	4c. County		9.31	Ъ	_
	Examin	er	4a. Facility Name (If not institut 11421 Monterr		iber)				Spri					omery		
	Funeral Director		5. Social Security Number 579-22-0458		7. Age (In yrs. i	last birthday) Yrs.	If Under Months		If Under:		8. Date of Birt (Month, Day July 23	y, Year) 3, 1915	9. Birtho Cour Vi	olace (State ntry) rgini	or Foreig a	gn
	D.		Usual Residence of Decedent										1	0d. Inside	Cib. Limit	10
	anytan show	-	10a. State 10b. Cour		10c. City	y, Town or Lo									s 21KIN	
	Ba-f	ecto		ntgomery		Silv	er Sp					10g. Citizen of	What Cou	ntry?		_
	a or 2	늅	10e. Street and Number 11421 Monter	rev Drive				2090	2			USA		,		
	eath	era	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13.				gin? (Sp	ecify Yes or No Rican, etc.)		ce - Americ			
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Maryland	d 2 shouth and N		19a. Informant's Name/Relation Willam L. Sa			19b. Mail						er, City or Town			D 20	90
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Baltimore,	Pages ment of ant: if i		1 🖫 Burial 2 □ Crematic 4 □ Donation 5 □ Other			linato				200	22 9	Arlin	gton,	Virg	inia	
Balt	permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m any injury or other traum QDGE.		21. Signature of Funeral Servi  23a. Part1. Enter the disease shock, or heart failure.	(Gell	/	5	00 Un	iver	sity	Blvc	1. W., S	l Home : Silver :	Inc. Sprin	g, MD	209	01
760, 0	Physician / Medical Examiner  Asician and prival-itansit is prival-itansit	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (	or as a consequence or a consequence or a consequ	quence of):										
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Division of Vital	or Attending ofter death. Director: After in by the fune	Certification:	3 Suicide 6 □ Coi	uld not be 28e. Ptace	of Injury - At hing, etc. (Speci							(Street and Num own, State)	nber or Ru	ral Route N	umber,	-
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	To the To the comple	Me	29b. Signature and title of cer		o Ma	n, M	Ø 29	c. Licens	se number	16		29d. Date sign Septem	bor 6	1. Day. Year 28, 20	009	
	•		30. Name and address of per-	son who completed caus	se of death (Ke	m 23a) (Type	KVI/le	Pik	e, 6-	-100,	Rockv	ille, I	nD.	2085	2	
4	St Regist	ate rar	31. Date filed (Month, Day, Young)	2009 Jen	Registrar's Sign	ature Sa	N.S.		/			7				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2. 2009 Month Physician Stottlemyer October 2, Robert РМ Joseph 3:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Boonsboro 6035 Appletown Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 29, 19 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 216-22-9493 1928 Maryland 81 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumattc event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6035 Appletown Road 21713 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XI Yes 2 □ No3/13/48 If Yes, Give Year or Dates: 1/16/51 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gay Easterday Stottlemyer Lovetta Chester Irving 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6035 Appletown Road Boonsboro, Maryland 21713 Robin T. Daymude / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery 10/07/2009 Boonsboro, Maryland 21. Signature of Funeral Service bicens Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, Maryland 21713 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Corebrovascular accident **Physician** month /Medical Due to (or as a consequence of) Examiner throsclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the burial-transit her tenson and Due to (of as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenc within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
OCFSHLV S, 2009 29c. License number 29b. Signature and title of certifier D44996 20311 Cappans Rd Bionsbon MD 21712-30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

for Marik

31. Date filed (Month, Day, Year) OCT 05

6+1

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryiand / i	•	tificate of	neaith and it Death		eg. No. 2009	33	104
	Physicia	an	1. Decedent's Name (First, Middle, La						Date of Death     Month		3. Time of	
	/Medic	al			Schneb	ly	41. O't. T	r Location of Death		r 3, 2009	7:25	<b>A.</b> M
	Examin	er	4a. Facility Name (If not institution, gi Homewood at Wi		rt		•	msport				
	Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last bii	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State	or Foreign
	Director		220-03-9423	1□ M 20X F	95	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, January	11,1914 M	aryland	
	m w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	ation				10d. Inside C	ity Limits
	Maryla f sho	o		.ngton	•		msport				1 □Yes	2 <b>X</b> No
	r 28a	irec	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	untry?	
	th with	alD	16505 Virgini	.a Avenue			21795	; ;		U.S.A.		
	r dea	Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be neithed at	y F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2 X N If Yes, Give Year or Dates:	lo	1	□Yes 2X1No	Specify:		Specify: Idb	i + 0	
Maryland 21215-0036	2 hour aturai	Completed by	15. Decedent's E	ducation	16a	. Deced	ent's Usual Occup	pation	1	16b. Kind of Business/	1te Industry	
215	thin 7% e. an "ni Medi	ple	(Specify only highest gi	rade completed) College (1-4or 5	+)	_		during most of work d)	ing			
21	ed wit ygien yer th	Con	Elementary/Secondary (0-12)			Se	cretary			Surgicia	I Clir	nic
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Las  Daniel Str		O = h = = h	<b>1</b>		18. Mother's Nam	•		£	
Ž	should nd Me mark matic	ပ္	19a. Informant's Name/Relationship		Schneb 19t		a Address (Street	Carrie and Number or Ru	Edi	City or Town, State, 2	fman Zip Code)	
Σ	nd 2 salth all		Richard W. Lauric							erstown, M		10
ore,	of He		20a. Method of Disposition			of Dispos	sition (Name of natory or other place	ce)	Date	20c. Location - City or	Town, State	
Ē	Page ment ant: If		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec					ery 10-07	-09 Н	agerstown,	Maryla	nd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Examinar is not be notified at once.		21. Signature of Funeral Service Lice	/						Home, Inc.		
	402 % 6		23a Part 1 Enter the disease or con		the death Do	not ente	O East Ar	ntietam S	treet, H	agerstown,	Approximat	te
	Dhysisian		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	e. (1918		(vois	Parten	TALL	,	Onset and	tween Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	of):	Con	1000000	5,016		2 60	- K
	Examiner		Conventially list and disagran	h								
	D ti	iner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	of):						
	xecute and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence	of):						
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner		200 10 (0. 00		J.,.						
687	ifficate g phys			α								
Box	th cer tendin	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth		h 3	Ectopic pregnanc	:v		23d. Date of de		V
о В	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 <del>□ N</del> o 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)	,		Month	Day	Year
σ.	that the	Phy	Part II. Other significant conditions	contributing to death be	nt pot resulting i	in the un	iderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of	death?
ds,	uires t signe ld be c	d by	Arkenson's 1	JOSEF.	Deno	ENT	14.		1 □ Ye	s 2-110 3 P	robably 4	Unknown
200	w req	lete	HUGE ATTU	UNI (=	Coci	110	WALL	Than	24a. Was a	n 24b. Were au	topsy findings	available
Division of Vital Records,	The la	Completed	LAFLETAN	<del>)</del>	C- 9	(A C	t	1.41.01	autops perforr	prior to death?	completion of o	cause of
ita	lan: 'artifica	Be C	25. Was case referred to medical examiner?					26. Place of Deal			2 🗆 140	
× ×	hysic this ce	၉	1 Yes 2 ₹No	· ,———	nt 2 ER/O	<u> </u>		4 Privursing no		ence 6 □Other (Spe	cify)	
n c	Ing P	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. <i>(, Year)</i>	Time of Injury	28c. Injur Wor M 1 □	k?	28d. Describe ho	ow injury occurred		
isi	Attenc death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	De 200 Place of Inju	ırv - At home, fa	arm, stre		Yes 2□No	28f. Location (St	reet and Number or R	ural Route Nur	nber.
<u>&gt;</u>	al or A safter I Dire	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	,	,,,		City or Town	n, State)		,
	To the Hospital or Attanding Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached			hysician: To the best of the basis of the ba								s)
	the H the F the F mplets	Medical	one) In Cali	and manner sta			29c. Licens			9d. Date signed Mont		
	5 <u>5 ≅ 5</u> ⊗		29b. Signature and filled of certifier	MATRICAN T	Intern	1 -	7	7/2		11/5/3/1	G	
			30 Name and address of person who	completed cause of d	23a) path (Item 23a)	(Type. )	Print)	146 )	~/	(0 ()/ 200	7/	
5	H-3		STEPHUE. MET	Ever les	134	24	(3 Ave	(TE-101	HAGGA	stean, W	d 2174	7
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		C	1	177			
	Registr	ar	UL   U 3	LUUX Alexander	and a	A	Carlin .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8 2009 4:00A heresa /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 1 F 87 215-14-1042 Director AUG 19 1922 Brunswick, MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD 1 X Yes 2 No Frederick Brunswick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 910 East "A" Street 21716 IISA Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within the and Mental Hygiene. 7 is marked other than "r First Baptist Church Elementary/Secondary (0-12) College (1-4or 5+) Secretary Brunswick, MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Thompson Virginia Hull 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an important: If Item 27 is many injury or other one. Larry S. Sheppard, Son 5002C Burkittsville Road, Burkittsville, MD 21718 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 ☐Removal from State 4 □ Doyation 5 Other (Specify) Union Cemetery 10/2/09 Lovettsville, VA 22 Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21. Signature di Eugliservice Licenste Williams Barbara A. Williams, Owner 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on explicit line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1112 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2000 1 □ Yes 3 Probably 4 Unknown Known to physicians as Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Hospital: Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) 29 32. Registrar's Signature Backs

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Day **Physician** 2009 12:10A M Stevenson Anita Vivian /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Capitol Heights 1615 Ruston Ave If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2√2 F Months Michigan 382-18-3771 Director 88 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Ersminer must be notified at 1 X Yes 2 □ No Director Capitol Heights Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 20743 1615 Ruston Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: Black Completed by 3€ Widowed 4 Divorced The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Ice Cream Maker 12±h is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill out of Health and Mental H It: If item 27 is marked ott y or other traumatic even Be Melvina Hillman Robert Lou Deane 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Ruston Ave Capitol Heights MD 20743 Paula E. Johnson Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 10/05/2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremetory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.Wesley Chavis III Funeral Service INCPA 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

10864 Southern MP BLVD Dunkirk, MD 20754 Approximate

Approximate

Approximate Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 autopsy perform certificate 1 ☐Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, Physician; or Attending 24 hours after deatl Funeral Director; filled in by the Hospital

within 2 To the

31. Date filed (Month, Day, Year) State OCT 0 2 2009 Registrar

ca

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

9500 ANNAPOLIS RUAL LANHAM, MD 20706 MD LEACH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

5 Pending investigation

6 Could not be determined

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			1 - State Registrar	State of Mary		•	tment of F ificate of I		nd Ment		ene () ()	5	33107
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	- 0					M	ate of Death onth		ear	3. Time of Death
	/Medic Examin		Ismael Burgos Sant  4a. Facility Name (If not institution, give stre				4b. City, Town, or	Location of F		tembe	r 28, 20		4:15 P <sup>M</sup>
and of	LXaiiiii	CI	9704 23rd Avenue	,				tsvill			Prince		orge's
	Funeral		5. Social Security Number 6. Sex 1 ■ M		In yrs. last birti 65		If Under 1 Year Months Days	If Under 24 Hours	Min. (N	ate of Birth lonth, Day,	/ear) 9	Coun	lace (State or Foreign try)
	Director		Usual Residence of Decedent		0.5				Mar	cn 17	, 1944 HU	maca	o,Puerto Rico
	arylan <b>show</b>	_	10a. State 10b. County		Dc. City, Town	or Loca	tion				-	11	Od. Inside City Limits
	the Ma 28a-f	Directo	Maryland Prince Geo	orge's	Hyat	ttsv	ille 10f. Zip Code			100	g. Citizen of Wha	t Cour	1 X Yes 2 No
	3a or		9704 23rd Avenue					783		100	US.		uy:
	ems 2	Funeral		Was Decedent Eve Armed Forces?	r in U.S.	13. Wa	as Decedent of H 'es, specify Cuba		n? (Specify Y	es or No-	14. Race -	Americ	
36	be filed within 72 hours after death with the Maryland nat Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Evariner must be notified.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 X No If Yes, Give		_	os, specify cube		Puerto		Black, \ Specify:		spanic
5-0036	2 hour		15. Decedent's Educati	Year or Dates: on			nt's Usual Occup	ation			6b. Kind of Busin		-
215	thin 73 ne. nan "n.	Completed	(Specify only highest grade co	College (1-4or 5+)		life. DC	nd of work done of NOT use retired	during most of l)	f working				
21	led wi dygier <b>her th</b> nt, the	Co	12			Wai	ter	40.14.11.1	Al /Fine	. A.C. alada	Restau	rani	
altimore, Maryland 2121	d d c	o Be	17. Father's Name (First, Middle, Last) <b>Eusebio Burgos</b>						iname (Firsi cia Sai		aiden Surname)		
ary	ges 1 and 2 should be f it of Health and Mental If item 27 is marked o or other traumatic eve	7	19a. Informant's Name/Relationship (Type.	Print)	19b.	Mailing	Address (Street				City or Town, Sta	ate, Zip	Code)
Ž,	1 and 2 Health a tem 27 is		Henry I. Burgos /	Son	32	209	Perry St	reet,	Mount	Raini	er, MD	209	12
ore	Pages 1, nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem	oval from State	20b. Place of cemetery	Disposit y, crema	ion (Name of tory or other plac		Date		c. Location - Cit	y or To	wn, State
<u>=</u>	permit. Pages Department of Important: If it any injury or once.	-0	4 ☐ Donation 5 ☐ Other (Specify)		Metropo	17	n Cremato		0/1/20				Virginia
Ba	perm Depa Impo any i	- (0	21. Signature of Funeral Service Licensee	Ay Roxus		Gas	Name and Addres	neral I		PA H	yattsvi1		re Avenue MD 20781
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the ause on each line.	e death. Do n	ot enter	the mode of dyin	g, such as ca	ardiac or resp	iratory arres	st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardiopul			est					1	Onder and Dodn
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и	⊒ ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a st			TITACIO						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Asthma Due to (or as a co		A).							
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	rtificat ng phy as the	<b>Nedical</b>	IF FEMALE:	1									
ROX	death certif e attending ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death		Ectopic pregnancy	y			23d. Date of		ery Day Year
j	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of death	5∐0	Other (specify)						July 70 a.
ν. σ.	requires that the	by Pr	Part II. Other significant conditions contrib	outing to death but n	ot resulting in	the und	erlying cause give	en in Part I.	2	3e. Did toba	cco use contribu	ite to th	e cause of death?
Kecords	v require been sig								- II.	1 ☐ Yes	2 □ No 3[	] Prob	ably 4 🔀 Unknown
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<u>=</u>	The stee								1	performe □Yes 2	ed? dea XINo 1□		2 🗆 No
VITal	Physician; this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hos	oital: 1  ☐ Inpatient	2 🗆 EB/Out	nationt	2□ DOA Othe	26. Place of	,		C   Other	(0 '6	
10 L	<b>5</b> 0 0	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day, Ye	28b. Ti		28c. Injury Work				ce 6 Other injury occurred	Specif	()
VISION	Attending r death. ector: After by the fune	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(menting isay, re		,,		Yes 2□No					
<u> </u>	al or Att s after d il Direct ed in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, fari Specify)	m, stree	t, factory, office		28f. Lo	cation (Stre ity or Town,	et and Number State)	or Rura	l Route Number,
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical (	29a. Certifier 1 ☑ Certifying Physici (Check only one)	an: To the best of m : On the basis of ex and manner stated	amination and	death o	occurred at the tir stigation, in my o	ne, date and p pinion, death	place, and di occurred at t	ue to the cau	use(s) and mann e and place, and	er as s d due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	-		-	29c. License	e number		290	d. Date signed (/	Aonth,	Day, Year)
	4		> Stun 7	Tu n	10		D	46998			9/29/2	2009	
10	4		30. Name and address of person who comp					11 -	77		100 00	700	
	Sta	e.	Steven Teksan Tee, 31. Date filed (Month, Day, Year)				eet, Sui	te #1,	Hyatt	svill	e, MD 20	782	
	Registra	ar	31. Date filed (Month, Day, Year) SEP 3 0 2009	32. Registrat's	Mark								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Steven Allen Stewart

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Physicia	n/	1. Decedent's Name	e (First, Middl	le,Last)					_		Mon	e of Death oth Day	v Year		3. Time of Death
Medical Examin	er	Steven A	llen S	tewart							Oct	ober 1, 20	09		0819 hrs
				on, give street and nu	mber)		4	b. City, Tow La Plata		ation of De	eath		4c. County of Charles	Death	
Service Control of the	Civista Med			7 4 /-	- Loud brinkle	1211	If Under		If Under 24	Hre 8 Da	ate of Birth(M		9 Birth	place (State or	
Funeral Director		<ol><li>Social Security N</li></ol>		6. Sex	7. Age (In yr:	s. last birtr	iday)	Months	$\rightarrow$		Min.	,		Foreign	
Director	L	217-60-8		1 X M 2 F	56		Yrs.				Jui	ne 4,	<u> 1953                                    </u>	Oodi	ntry Virginia_
any		Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town	or Location	on						T	10d. Inside City Limits
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Baltimore, permit. Pages I at Department of He Important: If ite	Ì	21) Si/nature of Fu		Licensee			22. N	lame and A	ddress of	Facility ]	Huntt	Funer	al Hom	e	
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ğ										_	1 Yes 2	2 No 3	Prob	ably 4 🗸 Unknown
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical	one)		and manner		on and/or I	. ivesuga		License r		at tile t				nth, Day, Year)
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**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:40 AM Stewart Sidney R. 2009 September 27 /Medical 4c, County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WORCESTER BERLIN NURSING & REHABILITATION CENTER BERLIN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 03/25/1921 Pennsylvania 204-05-3691 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 28a-f show injury or other traumatic event, the Medical Evaniner must be notified at 1 ☐Yes 2 No Director Ocean City Maryland Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA ŏ 21842 10329 Bristol Road or items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 XYes 2 No
If Yes, Give Merchant
Year or Dates: Marines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white ģ 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatin annual. Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Faye Coler Sydney Stewart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 10329 Bristol Rd., Ocean City, MD 21842 19a. Informant's Name/Relationship (Type. Print) Linda Strayer/daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 9/30/09 Salisbury, MD 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Holloway Funeral Home Professional 21. Signature of Funeral Service Licenses Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Ves No death? 1 ∐Yes **2 ⊿**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 12 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier HIVE address of person who completed cause of death (Item 23a) (Type, Print) Nam DR SALISBURY 614 EASTERN YOGESH SHORE VOHRA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SFP 30 Registrar

tewart, Sidne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#5,6pezcFH,9/30/09,BMV,McCo Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 0009 AM **Physician** 27-2009 urner llian /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Berlande Monto 6. Sex marban 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) f Under 1 Year | If Under 7. Age (In yrs. last birthday) 08351019909 NewTork **Funeral** Min. Months Days Hours 15 M 2 7 9 Yrs. 10 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MD Bethesda Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with USA 20817 6627 Radnor Road or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. ģ 3 X Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than "any injury or other traumatic event. If \*\*Mex Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Scheffres Fannie Bloom 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Winston-Salem, NC 27127 618 Cascade Avenue Stephen R. Turner-Son Baltimore. 20b. Place of Disposition (Name of B nai Israel 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/30/2009 Oxon Hill, MD Congregation\_Cemetery 21. Sign F 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 of Fundamental Survice Licensee MO1255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Nyucaz Physician disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner entonicular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed Due to (or as a consequence of): 68760. Physician/Medical for use as the Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2 No detached o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ANo 1 ☐ Yes 2 ☑ No 1 □Yes munic Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₽No 2 ER/Outpatient 3 DOA 1 Impatient Certification: To ot 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar nefruetra

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2009

31. Date filed (Month, Day, Year)

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3. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#5per:INF, 10-6-09, BMV, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 24, 2009 **Physician** Helen Tita 4:20 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 1802 Mt. Pisgah Lane Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 24, 9. Birthplace (State or Foreign 6 Sev 7. Age (In vrs. last birthday) **Funeral** <sup>Year)</sup>951 Months Days Hours Min. 1 □ M 2 1 XF Cameroon 57 Nov. **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 □ Yes ŽNo Director Prince George's Silver Spring Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, Its Medical Experies must be n 1802Mt. Pisgah Lane USA Funeral 20903 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify.Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Ś 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benard A. Tambu Siesga E. Unknown P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2583 Markham Lane, Hyattsville, MD 20785 19a. Informant's Name/Relationship (Type. Print) Nancy A. Tita/Daughter 20c. Location - City or Town, State Batibo Subdivision, Northwest Province, Cameroon 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Batibo Subdivision 1 Burial 2 Cremation 3 Removal from State 12, Oct. 4 ☐ Donation 5 Other (Specify 2009 Cemetery 21. Signature f uneral siving Liq Trancisdous of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Glioblastoma disease or condition resulting in death) 1 vear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼No 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 28-2009 Lamaman 10 MD035067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deepa Subramanian, MD 3800 Reservoir Road, NW, Washington, DC 20007 31. Date filed (Month, Day, Year) 3 Registrar's Signature State **SEP 30** Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year :45P M september 24, 2009 Thompson, Jr. Walter 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Lanham Doctors Community Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Min. Hours Months Days 1 ☑ M 2 □ F 70 7/13/1939 Washington, DC 578-48-8035 Usual Besidence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 √ Yes 2 No Capitol Heights MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 20743 7004 Hasting Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:1959-62 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor, US Patent Office Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Smith Walter Thompson 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20743 Capitol Heights, MD. Dorothy Thompson / Wife 7004 Hasting Dr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 10/3/09 Brentwood, MD. 22. Name and Address of Facility 21. Signature of Funeral Service licensee Fort Lincoln Funeral Home Dreta 3401 Bladensburg Rd. Brentwood, MD. Taxcos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tolloto Due to (or as a consequence of) HEON evit bono. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Togo Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death Month Dav 5 ☐ Other (specify) ☐Yes 2☐No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

execute

certificate be

Box 68760.

P.O. |

Division of Vital Records,

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evertimes is ust by notified at any injury or other traumatic event, the Medical Evertimes is ust by notified at any injury or other traumatic event, the Medical Evertimes is used.

Maryland 21215-0036

Baltimore,

and burial-trar attending physician the as nse Por sate has been signed by the page 2 should be detached certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Examiner Physician/Medical þ Completed Be P

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed' 2 XN0 1 □ Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident

6 Could not be 3 Suicide determined 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 F Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Priyestatin. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

certif 29b. Signature and title

MDD53066

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLD BRANCH AVENUE, Clinton ) AMANEZ 8909 ENTIQUE

State Registrar

Medical Certification:

31. Date filed (Month, Day, Year) 32. Registrar's Signatur OCT 0 1 2009

10+1

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Claire M. Thornton 7:01 PM september /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Coastal Hospice at the Lake Salisbury MICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth Month, Day, Year) 02/09/1927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. 221-14-9953 1 □ M 2 🔀 F Months Davs Hours 82 Delaware Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar most be reciffed at Wicomico Salisbury 1 ¥Yes 2 □ No Director Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1109 S. Schumaker Dr., Unit 3 21804 USA death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 X Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 🕱 No Specify: ģ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) health care nurse Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Marie McDermott Charles H. Thornton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any Injury or other trau once. 227 Canal Park Dr., Salisbury, MD 21804 Gilbert Thornton/brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 9/29/09 Salisbury, MD 21. Signature of Funeral Service Licens Nami and Address of Facility and Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 • 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 1RR2 /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed ng physician and as the burial-trar Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ₺ No 24a. Was an has autopsy After this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HCSP ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 09-26-2009 Garci 30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print) BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO M. 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 3 0 2009 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2009 Rae Lucille Taylor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 1520 Ramblewood Road Baltimore 8. Date of Birth (Month, Day, Year) Oct. 16, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 ☐ M 2 🗗 F Months Days Min. 85 Yrs. 1923 PA 213-20-0123 Director Usual Residence of Decedent 10d. Inside City Limits the Meryland 10c. City, Town or Location 10a. State 10b. County **Work** r then "neture!", or iteme 23s or 28s-f ehor the Medical Examiner must be notified at 1X Yes 2 □ No Baltimore Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21239 1520 Ramblewood Road deeth 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 72 hours efter 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify: Specify: Baltimore, Maryland 21215-0036 2 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Bookkeeper Education 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important; if item 27 ie marked othi any injury or other treumatic event, 9069. Be Edna M. Hoffacker Jesse H. Parrish ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 Macclesfield Dr., Medford, NJ 08055 Faye L. Boynton, Daughter Date 10, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Middletown Cemetery Freeland, MD 2009 \* 4 Donation 5 Other (Specify) 21. Signature of Pineral Service Licentee 22. Name and Address of Facility J.J. Hartenstein Mortuary, 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Idiopathic Hypertrophic Subacottic Stenssis Immediate Cause (Final disease or condition resulting in death) 2 years Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician end d be deteched for use as the buriel-transit The lew requires that the deeth certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Year Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 🕅 Ño 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Hypercholesterolemia Hypertension, Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t liractor, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D45708 /ally 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd, Baltimore, MD 21239 5601 Loch Raven J. KERKVLIET (JARY 31. Date filed (Month, Day, Year) 32 Registrar's Signature OCT 15 2009 State Registrar

DHMH 17 Rev 1/2001

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:35a Day 2009 Year Physician/ October 8 Clark Porterfield Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Care Center Harford Havre de Grace Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 1 🔀 M 2 🗆 F Days Hours May 31, 72009 Virginia Director 88 <u> 229–14–5235</u> Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Aberdeen Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21001 1620 Perryman Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1 V Yes 2 No If Yes, Give 1944–1946 Year or Dates. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) mechanic laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Blevins Thompson Andrew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1620 Perryman Road, Aberdeen, MD 21001 Minerva Thompson (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Harford Memorial Gardens 10/12/09|Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Maryland 21001-3399 Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 Yes 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ပ္ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		1 - For State Registrar	State o	f Marylan		artmen <i>tificat</i>			nd M		giene Reg. No.	009	33115
Physici		1. Decedent's Name (First, Middle Twin A Wielob								2. Date of Dea Month Sept. 2	25, Day	2009 Yeer	3. Time of Death 12:50 P M
/Medio Examin		4a. Facility Name (If not institution Holy Cross Ho		mber)				Location of Spri				County of Deat	
Funeral Director		5. Social Security Number None	6. Sex 1 □ M 2 1 F	7. Age (In yrs.	last birthday) Yrs.	tf Under Months	1 Year	If Under 2 Hours		8. Date of Birth (Month, Day 9 / 25 / 20	y, Yeer)	9. Birt Ma	hplace (State or Foreign cuntry) ryland
1 and 2 should be filed within 72 hours after death with the Maryland Health and Montal Hygene. Health and Montal Hygene. m 27 is marked other then "naturel; or Itams 23a or 28a-f show ther treumatic event, the Medical Examinat must be rediffed at	Director	Usual Residence of Decedent			y, Town or Lo	ark 10f. Zip	Code 912				_	en of What Co	-
be filed within 72 hours after death with the Marylan be filed within 72 hours after death with the Marylan Hygiene.  I won the than "naturel; or Itams 23a or 28e-f show and the Madical Examinat must be realified at	d by Funeral	11. Marital Status  125 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dec Armed Fo 1 Tyes If Yes, Gi Year or D	2X No		Was Deced f Yes, spec	dent of Hi cify Cubar	Specify:	jin? (Spe , Puerto l	ecify Yes or No- Rican, etc.)		orican Indian, e, etc. ite	
ed within 72 hygiene.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	College (	1-4or 5+)	16a. Deced (Give life.	kind of wo DO NOT u	rk done d	uring most			None		Industry
Mental Hy Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Brent Allen	Last)					A11i	son	(First, Middle, Wielobo	ob		
and 2 shulle and m 27 Is m		19a. Informant's Name/Relations Allison Wielobo			14 C	reșce	nt P	1ace	Tako	oma Parl Date	k, MI		
t. Pages rtment of rtent: If It njury or o		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S  21. Signature of Furfal Service	pecify)		Place of Disponentery, cremetery, cremetery, cremetery	Crem	ator	у 09	/30/	/2009 1 seph Gav	Falls	s Churc	h, VA
Depa Impo any is		23a. Part1. Enter he disease, or	Melly	caused the deat	51	30 W1	scon	sin A	ve.	NW Wasl	ningt	ton, DC	20016 Approximate
Physicien: The law requires that the death certificate be executed the second continuous pays the second continuous pays the second continuous pays of the second continuous con	dical Examiner	shock, or heart failwie. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Extr Due to b	eme Pre (or as a conseq (or as a conseq (or as a conseq	uence of): uence of):	ty 21	2/7	EGA					Onset and Death
the death certification of the attending of the attending of the attending of the ase as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown								2	23d. Date of delivery Month Day Year		
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The law recate has be page 2 sho	Completed									24a. Was autop perfo 1 Yes	osy irmed?		utopsy findings available completion of cause of
To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	Hospital: 1 28a. Date (Mor	Inpatient 2  of Injury oth, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injury Work	er: 4 □ Nu	rsing Ho	n (Check only on me 5 ☐ Resident 28d. Describe I	dence 6		acify)
oitel or Atte urs after de nrel Directo	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Plac build	e of Injury - At h ling, etc. (Specil	fy)					City or Tox	wn, State)	)	ural Route Number,
To the Hosp within 24 hor To the Fune completely fi	Medical					vestigation 29	c. License	oinion, dea	th occurr	ed at the time,	date and 29d. Date		e to the cause(s) th, Dey, Year)
		30. Name and address of person Randy Lizardo				Print)				MD 209			
Sta Regist		31. Date filed (Month, Day, Year,		Registrar's Signa				E -					

		1 - For State Registrar	State of Marylar		artment of F rtificate of		1		Reg. No.	009	3311/	
Physic	ian	1. Decedent's Name (First, Middle, Last	)					2. Date of De Month 09/25/		Year	3. Time of Death 1:10 P M	
/Medi Exami		Twin B Wielobob  4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location		09/23/		County of Death	1.10	
LXaiiii	ilei	Holy Cross Hospit			Silver	-	_		Mor	ntgomery		
Funeral Director		5. Social Security Number 6. Se None	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	3. Date of Bir (Month, Da 09/25/	th 17. Year) 2009	Cour	place (State or Foreign htry) 1and	
ITIQ Z I Z I D-DU3O  be filed within 72 hours after death with the Maryland lat Hygiene. I do ther than "natural", or Itams 23s or 28e-f show avent. The Medical Examinar must be notified at	by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD Montgomer  10e. Street and Number  14 Crescent Place	те	ry, Town or Lo	10f. Zip Code 20912	li	:-::2 <i>(</i> C	t. Von as No	Uni	en of What Cour ited Sta	tes	
2-UUSO 72 hours after d natural', or Itam		11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces?  1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		if Yes, specify Cub	Vas Decedent of Hispanic Origin? (Specify Yes or NYes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2☑ No Specify:			Specify:White		etc.	
d ZIZI3-U filed within 72 hc Hygiene. other than "natur ant, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire None	petion during mos d)	st of working	ing 16b. Kind of Busine			ness/Industry	
= m = 0 %	e	17. Father's Name (First, Middle, Last)		1		18. Moth	er's Name (	First, Middle	, Maiden S	en Sumame)		
ir yidilik should be i nd Mental I marked o matic ave	To B	Brent Allen				!		Wielobob				
Maryland nd 2 should be fill lith and Mental H. 27 Is marked oth		19a. Informant's Name/Relationship (T) Allison Wielobob /			•		Rural Route Number, Ci koma Park, I					
<b>Saltimore,</b> permit. Pages 1 ar Department of Hee Important: If Item any injury or otha		20a. Method of Disposition 1 □ Burial 2√□ Cremation 3 □ F	removal mom State		esition (Name of matory or other pla		Da			cation - City or To		
DAILLIN permit. P. Departme Important any injury	Brent Allen    Specific   Part						s Sons I	nc.				
by you, ireate be executed  Wedical Examiner  physician and s the buriat-transit	edical Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	guence of):	200000000000000000000000000000000000000						Approximate Interval Between Onset and Death	
death certif	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day		•		
w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause gr	ven in Part	l.		tobacco us Yes 2 ဩ		he cause of death? pably 4 Unknown	
The la ate has	Completed							24a. Was auto perfo 1 \( \text{Yes} \)	psy ormed?	prior to co death?	psy findings available mpletion of cause of	
vical r sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott			(Check only		□Other (Specif	64	
or Attanding Physician: free death. Director: After this certific in by the funeral director,	tlon: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wo		28	e 5∐ Hesi 3d. Describe			y)	
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	reet, factory, office		28		(Street and wn, State)		al Route Number,	
Lothe Hospital within 24 hours and to the Funeral completely filled	edical		sicien: to the best of my knowner: On the basis of examinating and manner stated.									
To the within 2 To the	Me	29b. Signature and title of certifier			29c. Licen: MD DO		34			signed (Month, 26/2009	Day, Year)	
		30. Name and address of person who c Rnady Lizardo MD	1500 Forest (	lon Po	Print)			MD 200				
St Regist	ate	31. Date filed (Month, Day, Year)	Registrar's Sign	ature	AL BIIVE	rohr	TIIE,	110 209	14			

			For State Registrar		State	of Marylan		artment of rtificate o		and Me		giene Reg. No.	009	331	18
	hysicia		1. Decedent's Nam	ne (First, Middle		vrd Lee	Whelto	n		2	2. Date of Dea Month 09	ath Day 28	2 0 0 9	3. Time of E 4:30	
	/Medic Examin		4a. Facility Name	(If not institution	, give street and nu			4b. City, Town,	, or Location of	of Death			ounty of Death		
			Arden C	Court As	sisted L	ivina		Silv	er Spr	ina		М	ontgom	ery	
Fu	ıneral		5. Social Security I	Number	6. Sex 1 <b>M</b> M 2 □ F	7. Age (In yrs. I		If Under 1 Yea Months Day	r If Under	24 Hrs. 8 Min.	B. Date of Birl (Month, Da		9. Birth	place (State or intry)	Foreign
Dia	rector		577-26-7			87	Yrs.				11/15/	1921		hington	, oc
and	*		Usual Residence of	10b. County		10c. City	, Town or Lo	cation				-		10d. Inside City	v Limits
Maryl	fsho	o	MD	Hout	a amaku				uat Cn	n i wa				1 ☐ Yes	2 <b>X</b> No
the the	28a-	rec	10e. Street and Nu		gomery			10f. Zip Code	ver Sp	uny		10g. Citize	n of What Cou	intry?	
with	3a or	Funeral Director	3112 Gra	colield	Road, #4	102		· ·	2090	A			u.s.		
death	ms 2	ner	11. Marital Status	шеднеш	12. Was Dec	edent Ever in U.S	S. 13.	Was Decedent of If Yes, specify Cu			ify Yes or No	- 14	Race - Amer	ican Indian,	
<b>6</b>	or ite	₫	1 Never Mar	ried 2 Marr	Armed For ied 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					i, Puerto R	ican, etc.)		Black, White,	etc.	
<b>6</b> 03	Exa.	l by	3 🗆 Widowed	4 Divorced	Year or E	Dates: WWII		1∐Yes 2∭XN	o Specify:			S	pecify:	White	
<b>5-6</b> 72 hc	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ital Medical Experimental be notified at once.		(Spe	15. Decedent	's Education st grade completed)		16a. Dece	dent's Usual Occ	upation	t of working	, ,	16b. Kind	of Business/Ir	ndustry	
اة ق اق	han "	Completed	Elementary/Sec		College (		life.	DO NOT use reti	red)		,		11.1:	0	
led w	her t	ပိ	47. Fellowie Niero	/F:	5-	<b>F</b>	FC	unily Ph			Time Adiabatha	Administra Co	Medi	cae	
and t be fi	ed of	Be o	17. Father's Name	, , ,	us Wheltoi				18. Mothe	,	First, Middle,		•		
ryl hould	mark	2	19a, Informant's N			r .	10b Mailie	ng Address (Stre	at and Numbe		drica			in Cadal	
Ma Id 2 s	27 is trau				helton -	Spouse		Gracefi				. ,			904
<b>.</b> Hear	other	1 8	20a. Method of Dis		nexon			sition (Name of natory or other p					tion - City or T		704
nol	y or o				3 🗆 Removal from	State		natory or other p <b>coln Cre</b>	lace)	10/01	2009	Drout	wood I	Marylan	J
artm	ortan Injur	Ť	21. Signature of F	5 Other (S)	1 /		. LUIU	2. Name and Ado	ress of Facilit	v Hino	L-Ding	Pdi F	woou, i	Home	Inc
Den Den	any Ir		D. Alia	1000	Maryo	100241		800 New							
			23a. Part 1. Enter	the disease, or art failure. List	complications that	caused the death							СОРОС	Approximate Interval Betw	veen
Phys	sician	5 1	Immediate Cause disease or conditi	(Final	A	12h	ein	215	115	eus			1	Onset and D	eath a_{
	edical		resulting in death)	)	a. Due to	(or as a consequ		- 0	0.0	Colj				J	ul J
Exar	miner		Sequentially list co	anditions	b										
A 70	sit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease of	mmediate enging	Due to	(or as a consequ	ience of):								
b ecut	and -tran	каш	that initiated event resulting in death)	IS	C	(24.22.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2									
	ohysician and the burial-transit		, , , , , , , , , , , , , , , , , , ,		Due to	(or as a consequ	rence or);								
	phys the	dical			d	<u> </u>									
X 6 certific	attending I	Me	IF FEMALE:		23c If yes ou	tcome of pregna	nev								
Box eath cert	for u	ian	23b. Was deceder in the past 12	2 months?	1 ☐ Live	birth 2 Fetal	death 3[	Ectopic pregna Other (specify)				23	d. Date of deli- Month	-	ear
o g	y the	ysic	1 ☐ Yes 2 9 ☐ Unknowr		9 ☐ Unki	nown	eau 5L	1 Other (specify)							
Division of Vital Records, P.O. Box 6 to Attending Physician: The law requires that the death certificater death.	detached	Completed by Physician/Me	Part II. Other signi	ificant conditio	ns contributing to d	eath but not resu	Iting in the u	nderlying cause g	given in Part I.		23e. Did to	obacco use	contribute to	the cause of de	eath?
ds .	signed Id be det	d b	HV	nect.	en sion						1 🗆 🕆	Yes 2.⊡	No 3□Pro	bably 4 🗌 Ui	nknown
	s been si	ete	//								24a. Was	an I	74b More out	oncy findings o	wailabla
<b>Be</b> is	e has	du									autor		prior to c death?	opsy findings a ompletion of ca	use of
[a]	certificate ector, pag	රි .	25. Was case refe	wed to medical							1 □ Yes	2 🖼 No	1 ☐ Yes		
Sicia	nis certificate ha director, page	) Be	examiner?	/	Hospital:		<b>FB</b> (0tt)		thor:		Check only o		1+51		vrng
<b>₽</b> ₹	er this eral dii	Ĕ	27. Manner of Dea			Inpatient 2 🗀 I of Injury oth, Day, Year)	ER/Outpatier 28b. Time o	IL OLI DOX	4 🗀 NU		e 5 🔲 Resid d. Describe l		☑Other (Spec	ity) FUCI/1	17
e ding	After funera	ij	1 Matural 2 ☐ Accident	5 ☐ Pending investig		nth, Day, Year)	Injury	W	ork? □Yes 2 □I						
/iSi Atter	oy the	lica	3 🗌 Suicide	6 ☐ Could n determi		I of Injury - At hoing, etc. (Specify	me, farm, str				f. Location (5	Street and I	Number or Rui	ral Route Numb	per,
affer affer	d in	Certification: To	4  Homicide	determi	build build	ing, etc. (Specify	)	,,			City or Tov	wn, State)			
Div	To the Funeral Director: A completely filled in by the fi	alc	29a. Certifier	1☑ Certifyin	g Physician: To the	e best of my know	wledge, deat	h occurred at the	time, date ar	nd place, ar	nd due to the	cause(s) a	nd manner as	stated.	
ne Hc	he Fu	Medical	(Check only one)	2∐ Medical I	Examiner: On the t	pasis of examinat oner stated.	tion and/or in	vestigation, in m	y opinion, dea	th occurred	d at the time,	date and p	ace, and due	to the cause(s)	
Vithi	com	Ž	29b. Signature and	d title of certifier					nse number				signed (Month		
10	+1		Pour	ent				04	3237			Jep	tember	- 29, 2	009
			30. Name and add	lress of person	who completed cau		23a) (Type,	Print)		c .	,				
			raul A		-ong, M.	,	201 L	Print) awe/P	K. Pri	#102	L LAU.	rel, n	10 20	707	
F	Stat Registra	.6	31. Date filed (Mor	nth, Day, Year)	2009	Registrar's Signat	ure ba	Ked							

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death g Month 25 20ď9' Mildred Pauline Webber 8 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick 6507A Mountain Church Rd. Jefferson Birthplace (State or Foreign Gountry) A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 😿 F Months Days Hours Min. 96 217-32-5890 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Frederick 1 ☐ Yes 2X No Jefferson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6507A Mt. Church Rd. 21755 USA

1 □Yes 2 X No

16a. Decedent's Usual Occupation

homemaker

20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cemetery

or compliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

14. Race - American Indian,

White

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

6607 Jefferson Blvd., Frederick, MD 21703

Goldie Mann

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

9/28/09

Donald B. Thompson Funeral H POB 18, Middletown, MD 21769

16b. Kind of Business/Industry

own home

20c. Location - City or Town, State

Burkittsville, MD

Approximate

College (1-4or 5+)

Physician /Medica Examine 1 - State Registrar

10a. State MD

11. Marital Status

1 ☐ Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

Charles Homer Tritapoe

Mary Cashour (Daughter)

5 ☐ Other (Specify)

3 □Widowed 4 □ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition 1 X Burial

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

2 Cremation

Director

Funeral

þ

Completed

Be

မ

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Extraoring must be rotified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition		tong Disease			Onset and Death				
	resulting in death)	Due to (or as a consequence of):								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b								
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year				
d by Ph	Part II. Other significant conditions	contributing to death but not resulting in the unc				o the cause of death?				
Completed				24a. Was an autopsy performed 1 □ Yes 2 ☑	2 death?	utopsy findings available completion of cause of				
Be	25. Was case referred to medical examiner?		26. Place of D	Death (Check only one)						
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 □ DOA Other: 4 □ Nursing	g Home 5 Residenc	e 6 □Other (Spe	ecify)				
ation: 1	27. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how i						
Certification: To	3 ☐ Suicide 6 ☐ Could not determine		et, factory, office	28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,				
Medical (		Physician: To the best of my knowledge, death aminer: On the basis of examination and/or invand manner stated.								
Š	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mon	th, Day, Year)				
	(run) E	ses no	016939		9/28/4	٩				
	30. Name and address of person who	completed cause of death (Item 23a) (Type F	Print)	21759	1					
ite ar	31. Date filed (Month, Day, Year)	o completed cause of death (Item 23a) (Type P	parker							
001		,								
		ADI:	CINIAL							

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SON RGINI 2009 20/ 401 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** HUSPITAL SHADY RUCKVILLE GROVE MONTGOINE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 218-94-5692 Months Days Hours Min. 69 OF COLLUNGA **Director** NSTRUI Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show event, the Medical Examiner must be notified at POTOMAC 1 ☑Yes 2 ☐ No MONTGOME Director 110 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? US A 12621 20854 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify þ Specify: BLACK 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Şecondary (0-12) College (1-4or 5+) Home permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: if Item 27 is marked other than any injury or other traumatic event, Inc. M. app. once. HOUSE WIFE unichan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHNSON BIRDIE DAVIS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK 12628 Tobytown Dr. Totomac Mo WILSON 20859 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MO 26, 2009 MARKS COM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lenny 22. Name and Address of Facility GARY L. RULLIUS FW. HONE yeund. wille 21701 FREDERICK MS SOUTH 51 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ves Physician auves disease or condition resulting in death) /Medical Due to (or as a conseque nce of) Examiner disease Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ZNo 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 1 Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (rest

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 5 of Maryland Department 2011 death and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2:20am RONALD VINCENT WILKERSON eptembe 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Med late Ka 578-52-2520 576-52-2520 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) JANUARY 14, 1939 1 □ xM 2 □ F Months Days Hours Min WASHINGTON, D.C. 70 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 TyYes 2 □ No MARYLAND CHARLES MARBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4220 CHICAMUXEN ROAD 20658 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1**X** Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 YEAR (1-4or 5+) Elementary/Secondary (0-12) ELECTRONIC TECHNICIAN FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES LESTER WILKERSON PAULINE MARBURY WILKERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILLIAN WILKERSON / WIFE 4220 CHICAMUXEN ROAD, MARBURY, MARYLAND 20658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 **X** Cremation 3 Removal from State BRINSFIELD-ECHOLS CREMATORY OCT. 2, 2009 CHARLOTTE HALL, MARYLAND 4 Donation 5 Dother (Specify) nature of Funcial Service Licensee NTON FUNERALIVINGSTON LHOME, P.A. ROAD, INDIAN HEAD, MARYLAND 20640 PLYDIA C. THORNTON JOHNSON MO0583 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque that initiated events resulting in death) Last Due to (or as a conseque IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use conribute to the cause of death? 2000 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 X X 0 1 Yes 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No

**Physician** /Medical Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-tran and the attending physician

Examiner

**Physician** 

Examiner

**Funeral** 

Director

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23a

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Department of Hes Important: If item

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Baltimore,

Division of Vital Records, P.O. Box 68760,

other traumatic event, it is Medical Examiner must be notified at

**Funeral Director** 

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Completed

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10a. State

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Physician/Medical 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be Certification: To 1 ☐ Y96 27. Ma er of Death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated. Medical 29a. Certifie , death occurred at the time, date and place, and due to the cause(s) and manner as stated d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signa re and title of certific 29c. License number 29d. Date signed (Month, Day,

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State

Registrar

SONY CHOL 31. Date filed (Month, Day, Year) 30 2009

່ວ∫ s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

**Physician** /Medical Examiner **Funeral** Director show

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3675 Solomons Island Road Harwood 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 31, 7. Age (In yrs. last birthday) 6. Sex Months Days Hours 1 □ M 2 🗷 F Yrs 63 513 46 2260 Usual Residence of Decedent 10b. County 10c. City, Town or Location Examiner must be notified at Director Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code 6 9310 Pineview Lane 20735 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give X Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1<sup>College (1-4or 5+)</sup> Elementary/Secondary (0-12) Hairdresser permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any injury or other traumatic event, Its. once. 17. Father's Name (First, Middle, Last) Be Hillary T. Williams Leona 2 19a. Informant's Name/Relationship (Type. Print) Helen Church (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 0ct 5, Dato 09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Thomas Church Cemetery 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Sei -moo257 mark and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by autopsy performe certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation neral Director: A 1 Tyes 2 🗌 No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier Medical and manner stated 29b. Signature and title of certifier Name and address of ed cause of death (Item 23a) (Type, Print) serson who comple VICH AR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAMS 0300M ARON 4c. County of Death Anne Arundel 9. Birthplace (State or Foreign 1946 Idaho 10d. Inside City Limits 1 □Yes 2□No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Costmotology 18. Mother's Name (First, Middle, Maiden Surname) May Bivins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 Laurie Place, Pomfret, MD 20675 20c. Location - City or Town, State Croom, Maryland 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death MOS 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No Other (Specific +OSDICE 28d. Describe how injury occurred HOUSE Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Registrar

		1 - State of Maryland / Dep Registrar Ce	artment of Health and N ertificate of Death		ene g. No. 2005	33123					
Physic		Decedent's Name (First, Middle, Last)  Roslyn Young		2. Date of Death Month	29 <sup>ay</sup> 2009	3. Time of Death 05:09A M					
/Medi Exami		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	3	4c. County of Death	ry Co.					
Funeral Director		5. Social Security Number  213-86-5500  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 Jusual Residence of Decedent	) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 07-16-	Year) 9. Birth Cou. 1962 Was	place (State or Foreign ntry) h., D.C.					
Ind 21215-0036  be filed within 72 hours after death with the Maryland hat Hygiene.  dother than "natural", or Items 23a or 28a-f show event, Ita Madical Exprise fromst be notified at	Funeral Director	10a. State			g. Citizen of What Cour  USA  14. Race - Ameri Black, White,	can Indian,					
21215-0036 I within 72 hours after giene. I man "natural", or i	Completed by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	adent's Usual Occupation e kind of work done during most of work DO NOT use retired)  1rsing Assistant	ing 16	Specify: Black  16b. Kind of Business/Industry  Private Industry						
	To Be C	17. Father's Name (First, Middle, Last) Bravell Young	18. Mother's Nam	e (First, Middle, Ma Lia Year	aiden Surname)	nauscry					
		Robyn Pollard (Sister)   1352	ing Address (Street and Number or Rui 20 Parkford Mand Yer Spring, Mary osition (Name of	or Drive /land	City or Town, State, Zip 20904  Oc. Location - City or To						
Dartillore, permit. Pages 1 ar Department of Hea Important: if item; any injury or other		20b. Place of Disposition   20b. Place of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c. Location - City or To									
Physician //Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nter the mode of dying, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death					
The COIGS, P.O. BOX 68/60,  The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the bunal-transit	Physician/Medical Ex	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	□ Ectopic pregnancy □ Other ( <i>sp</i> ec <i>ify</i> )		23d. Date of deliv Month	ery Day Year					
lecords, law requires th has been signed 2 should be de	Completed by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		24b. Were auto						
VICAL FIGURE THE CERTIFICATE DESCRIPTION PAGE	Be Con	25. Was case referred to medical examiner?  Hospital: Hospital:	T	performe	ed? death? ⊇No 1 □ Yes	·					
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	1 ☐ Yes 2 ☑ No  1 ☑ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  1 ☑ Inpatient 2 ☐ ER/Outpatie 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 2 ☐ Suicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, stee building, etc. (Specify)	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	et and Number or Rura						
the Hospite nin 24 hours the Funeral npletely fille	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau	use(s) and manner as see and place, and due to	stated. o the cause(s)					
To with con	2	29b. Signature and title of certifier	29c, License number D65953	290	d. Date signed (Month,						
R Sta		30. Name and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$500 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of death (Item 23a) (Type, Dr. Adaku Onukogu \$510 graphs and address of person with completed cause of person with cause of person with cause of person with cause of person with cause of person with cause of person with cause of person with cause of person with cause of person with cause of person with cause of person with cause of person with cause of person with cause of perso	Print) Forest Glen Ro er Spring, Mary	ad <del>/land</del>	20910						

31. Date filed (Month, Day, Year) OCT 0 2 2009 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 28, 2009 11:00 A M Thelma D. Young September 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min. 1 □ M 2 □ F 4/26/1929 Philadelphia, PA 186-24-4642 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County Prince George's X Yes 2 No District Heights 10f. Zip Code 20747 Street and Number 10g. Citizen of What Country? 2609 Timbercrest Dr. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status rmed Forces? ☐Yes 2[X] No 1 Never Married 2 Married If Yes, Give Year or Dates: Specify: Black 1 ☐Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Elizabeth Banks James Christopher Dixon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Timbercrest Dr. District Heights, MD 20747 Shamar Smith Sr. (Grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 10/5/2009 Brentwood, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funera Se callic nsee 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirator disease or condition resulting in death) Due to (or as a contequence of): CAMIBO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cononau Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

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Completed

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MD

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm "had of Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any lijury or other traumatic events.

Examine sician and burial-transit attending physician for use as the buria Physician/Medical signed by the a d be detached f icate has been s Completed certificate Be Certification: To this funeral e Hospital or Attending P 124 hours after death. e Funeral Director: After t After t

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

24a. Was an autopsy performe 1 ☐ Yes 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 ☐ Yes

examiner?								
1 Yes 2	lo	Но	spital: 1 ☐ Inpatient	2/2	ER/Outpatient	3 🗆 1	DOA	Ot
27. Manner of Death Natural 2 ☐ Accident	5 Pending investigation		28a. Date of Injury (Month, Day, Ye	ar)	28b. Time of Injury	M	28c.	Inji Wo
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	9	28e. Place of Injury - building, etc. (\$	At ho	ome, farm, stree	t, facto	ry, of	fice

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c, License number

28d. Describe how injury occurred

29a, Certifier (Check only 2 Medical

25. Was case referred to medical

29b. Signature and title of certifie

😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0041580

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clinton, Md 0

State Registrar

filled in by the

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1, ZUCK 5:30AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Manor Care Montgomery Potomac Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Hours **Director** 119-34-7280 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2813 Huntsman Way <u> United States</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Private-Social Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Weintraub Molly Feldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Paul Zucker</u> 12813 Huntsman Way Potomac MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cametery, creamatory or other place)
Garden of Remembrance
Memorial Park 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/30/2009 Signature of Faneral S 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADVANCEN Physician/ disease or condition resulting in death) Medical Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🗓 No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 24 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗶 No Other: 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: of the found of 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifie 28/09 00057458

Registrar DHMH 17 Rev 7/2009

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129

suit#101 Riverdale, MD 20737

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6502 Kenilworth Ave

Pinky Singh MD

30

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma	ryland /		rtment of F tificate of			giene Reg. No. 2 0 10 (	33126
	Physici	an	1. Decedent's Name (First, Middle, Last)		411				2. Date of De Month	ath Day Yea	3. Time of Death
	/Medic	al	Ruth G	race	Abb	ott	4h City Town o	r Location of Deat	Octobe:	r 14, 2009	10:40 p.M
أر	Examin	er	Holy Cross Hospita				Silver S			Montgome	
F	Funeral Director		5. Social Security Number 6. Sex 1 □ 1 06 − 14 − 0194	7. Age И 2⊠F	(In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th year) 9. E 9, 1920 New	irthplace (State or Foreign Country) W York
	ъ		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Maryli I-f sho	tor	MD Montgomery		Takom						1. 2 Yes 2 □ No
	th the	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of What (	
	sath w	Funeral Director	7416 Holly Avenue	Was Decedent E	vor in II C	12 1	20912	lianania Origina (6	Specify Vale or No	United St	ates nerican Indian,
036	urs after de al", or Item	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:			Vas Decedent of H FYes, specify Cuba □Yes 2⁄1 No	an, Mexican, Puer	to Rican, etc.)	Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, I'm Modical Evol in more instituted at once.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+	,	(Give life. L	lent's Usual Occup kind of work done OO NOT use retired	pation during most of wo	rking	16b. Kind of Busines	ss/Industry
121	iled wi Hygier Ither th	Cor	17. Father's Name (First, Middle, Last)			DOOK	keeper	18 Mother's Na	me (First Middle	Maiden Surname)	
<u>lan</u>	uld be i Mental rked o tic eve	To Be	George Yalsic						Prohovi		
Maryland	12 shou h and h 7 Is ma trauma		19a. Informant's Name/Relationship (Type Susan A. Arisman	. Print) (daughte	1					er, City or Town, State field. Ver	
ē,	s 1 and if Healt item 27 other 1		20a. Method of Disposition	(daugnte			sition (Name of patory or other place	1	Date	20c. Location - City	
Baltimore,	Page ment o ant: If lury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Chesa	peak	e Cremato	ory [ 2	ber 16,		e, Maryland
Ball	permit. Depart Import any Inj		21. Signature of Funcial Service Licensee	1	M00982					al & Crema ng, Maryla	tion Service nd 20910
1	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line	e.		er the mode of dyir		c or respiratory a	rrest,	Approximate Interval Between Onset and Death Days
	/Medical Examiner		resulting in death)	Due to (or as a			Effusion	20			Days
	±. q	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequenc	e J).					
	execute n and al-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Bilatera Due to (or as a			Infitrat	es			Days
28/60,	ficate be executed physician and s the burial-transit	dical	d.								
_	certifica nding phase as the		IF FEMALE:	. If yes, outcome o	of pregnancy					004 8-4-4	1-11
O. BOX	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal dea		Ectopic pregnanc Other (specify)	y		23d. Date of o	Day Year
ds, P.	uires that n signed b Id be deta	ρ	Part II. Other significant conditions contr Probable circulato		t not resulting	g in the ur	derlying cause giv	en in Part I.			to the cause of death?  Probably 4 Dunknown
ecords,	law req as beel 2 shou	Completed	Hypothyroid						24a. Was		autopsy findings available to completion of cause of
י י	n: The icate h r, page								perfo 1 □ Yes	ormed? death 2 DHo 1 □ Y	
> .	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 27 No	spital:	nt 2 ER/0	Outnatien	t 3 DOA Oth	or:	ath <i>(Check only c</i>	one)dence 6 □Other (S	nacify)
	ng The	ion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	y 28b	Time of Injury	28c. Injur Wor	y at k?		how injury occurred	респу
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuit building, etc.	ry - At home, (Specify)	farm, stre		Yes 2 □ No	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
_	e Hospita 124 hours e Funeral letely filled	Medical C	29a. Certifier 1 Sertifying Physic (Check only one)		examination						
:	Vithir vithir comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
				enich,				65485		10-15-	-09
-			30. Name and address of person who/com Barbara Ann Supani	ch, M.D.	1500 atm (Item	For	est Glen	Rd. Sil	ver Spri	ng, MD 209	10
H	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrá	r's Signature	1	back	,			

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ye ar Month **Physician** 29 PM WESTON L. ALEXANDER JR. PCCS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAR ENTE If Under 24 Hrs. Birthplace (State or Foreign Country) f Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 ፟ M 2 □ F WASHINGTON, DC 52 SEPT. 1957 8 Director 579-78-5623 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show, permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'ms Medical Evarvings must be notified at 1K Yes 2 □ No Funeral Director LAPLATA MD CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20646 1009 SWEETGRASS CIRCLE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No BLACK Specify: ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NAT'T AIR GUARDSMAN GOVERNMENT 3 YRS 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be MARY ELIZABETH HAYNIE WESTON L. ALEXANDER SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1009 SWEETGRASS CIRCLE LAPLATA, MARYLAND 20646 JACQUELINE ALEXANDER/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 10-16-2009 CLINTON, MARYLAND 4☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Ston Muston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MINUte **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Tyes I or Attending Physician: after death. Director; After this certifica 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 MER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AHENDINT COVERAGE 44436 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POST OFFICE RD, WALDORF ASHVINKUMAR 31. Date filed (Month, Day, Year) State Registrar

Division of Vital Records, P.O. Box 68760

Examiner sician and burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician I be detached for use as the buria After this certificate has been situated the funeral director, page 2 should be within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

**Physician** 

/Medical

Director

Funeral

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar, just be notified at once.

Physician /Medical

Baltimore, Maryland 21215-0036

Adla

Braton

31. Date filed (Month, Day, State

o pe combiered by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 L Yes	2.⚠No Specify:		Specify: Mack
	15. Decedent's Ed (Specify only highest gra	Jucation 16 ade completed)	a. Decedent's Us (Give kind of v	sual Occupation york done during most of work use ratiod)	king 16b.	Kind of Business/Industry
-	Elementary/Secondary (0-12)	College (1-4or 5+)	life. PNOT	use ratived)	1	totes
	17. Father's Name (First, Middle, lest) ASNUEL DE	rown		18. Mother's Nam	ne (First, Middle, Maide 7: Will	en Surname)
	19a. la rmant's Name/Beletionship (	Type Print) (daughter)	9b. Mailing Addre 10302 ~	Sunny lake	PL APT	R COCKEYS VISIE, INC
	20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ 4 Donation 5 □ Other (Specific		of Disposition (A tery cleanory	ame place / O/	3/09 = 20c.	Location - City or Town State Md .
	21. ignature of Funeral Service Licental	e Konn	22. Name 274	and Address of Facility of State of Sta	the Br	Tunesof Home
	hock, or heart failure. List only	plications that caused the death. Do one cause on each line.	o not enter the m	ode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
1	Imm ediate Cau e (Final disease or condition r sulting in death)	a Congestive	- Hear	rt talline	. Sellele	MRITE
4		Poue to orles a consequence	eof):	aut ctara	3 10	um -11+1)_
ı	Sequentially list conditions, if any, leading to immediate	<u> </u>				
ı	cause. Enter Underlying Cause (Disease or injury that initiated events	Chronic A	nenu	cu -		
ı	resulting in death) Last	Due to (or as a consequence	e of):			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ≥ □x√No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		c pregnancy (specify)		23d. Date of delivery Month Day Year
	Part II. Other significant conditions of	contributing to death but not resulting	in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
	Atorial Fibri	llation.			1 ☐ Yes	2 No 3 Probably 4 Unknown
	The on bo at	o heura.			24a. Was an	24b. Were autopsy findings aveilable prior to completion of cause of
	Rectoritation	unot	1 Seas	0	autopsy performed	death?
	25. Was case referred to medical	2000	ع)مارا		1 □Yes 2 ☑1 ath (Check only one)	No 1 ☐ Yes 2 ☐ No
	examiner? 1   Yes 2   No	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 🔽	Othor:	lome 5 Residence	6 ☐ Other (Specify)
	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b	. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred
1	2 Accident investigation 3 Suicide 6 Could not be		M	1 □Yes 2 □No		
	4 Homicide determined	e 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, fact	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	29a. Certifier 1 CertifyIng Ph (Check only one) 2 Medical Exar	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	ge, death occurr and/or investigat	red at the time, date and place ion, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) end manner as stated. and place, and due to the cause(s)
	29b. Signature and title of certifler			29c. License number	29d. l	Date signed (Month, Day, Year)
	D CHATE	annu m	(D-	D6721+	10	08 2009
	30. Name and address of person who	completed cause of death (Item 23a	a) (Type, Print)	ativity and a little	D 22 6 1-	The Adams Nice
	Z. HHSHW	11. ITTOQUE C	ex He	wer co.	RIMS 1	CUS Laurent Blue

Registrar

Bouth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10-14-2009 **Physician** 0615 A M Joseph C. Burdick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air Upper Chesapeake Mecial Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-29-1928 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Months Hours Min Days 1 X M 2 □ F IA 80 480-22-3459 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 Yes 2 □ No Director Harford Bel Air MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21015 503 David Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ∐Yes 212 No Specify: Specify: White ð 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Staff Sergeant US Air Force GED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Edith Fields Faye Edward Burdick ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Burdick (Son) Bel Air MD 21015 503 David Drive 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BGWCD Vet. Mem. Cem. 10-20-2009 North Hanover, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final gisease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes Z⊠No 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural

P.0. Division of Vital Records, r Attending Physician:

led by the attending physician detached for use as the buria After this certificate has been signed funeral director, page 2 should be det n 24 hours after death.

e Funeral Director: Afterely filled in by the fur Hospital

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

Examiner

800513 CG7 10/14/69 06 15 0M Baltimore, Maryland 21215-0036

5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

(Check only one)

and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Per Chesapeake Dr. Bel A.V., M. BUOH

State Registrar

Medical

31. Date filed (Month, Day, Year)

within 2 To the I

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 10-12-2009 1844 P M Davood Badie 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02–22–1930 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Country) Iran Days Hours 1**⊠** M 2□ F 79 212-46-7260 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 ☑ No MD Harford Bel Air 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21014 130 Glenwood Rd 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Pediatrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Saltanat Badie Ali Mohammed Badie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 130 Glenwood Rd Bel Air, MD 21014 Elinor Jeanne Badie (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gar. 10-16-2009 Fallston, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) \*ARTERIOSCLEROTIC CARDIDVASCULAR DISEASE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a schedulence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown PARKINSONS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed 2 ☑ No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 3□ DOA 27. Manner of Death 28d. Describe how injury occurred

**Physician** /Medical Examiner Badie Navord Mocood Stone Box 68760

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r 28a-f sh notified a

must be n

7 is marked other than "natu traumatic event, the Medical

Department of Important: If it any injury or o once.

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Examiner Physician/Medical Certification: To Be

Completed by

Medical

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending

1 Natural 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

OCTOBER 13, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEL AIR 2 NORTH AVE

State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

	-	State State Registrar	of Maryland /	-	rtment of F tificate of t			giene Reg. No. 2	119	33131
Physicia /Medica	_	Decedent's Name (First, Middle, Last)  Glessie Biddle					2. Date of Dea Month 10-11-20	Day	Year	3. Time of Death 705 A M
Examine	r	4a. Facility Name ( <i>If not institution, giv</i> e s <i>treet and n</i> Forest Hill Health & R	ehab.		Fores	Location of Death			ford	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 08-11-	y, Year)	9. Birthpi Coun	lace (State or Foreign try) NC
e Maryland ka-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         Harford	10c. City, To	own or Loc						0d. Inside City Limits 1 ∐Yes 2X No
th with the	Funeral Director	10e. Street and Number 807 Dellwood Drive			10f. Zip Code	21047		10g. Citizen of V USA	√hat Coun	try?
Irs a	2	Armed F	2 X No aive X No		Vas Decedent of H f Yes, specify Cuba I □Yes 2ሺNo	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White, e	
within 72 ho lene. than "natur	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	(Give :	lent's Usual Occup kind of work done OO NOT use retired itry Boa	during most of worl ii)	sing		d of Business/Industry  Lectronics	
ld be filed fental Hyg rked other tic event,	o Be C	17. Father's Name (First, Middle, Last) Andrew J. Bailey				18. Mother's Nam Hannah	e (First, Middle, M. Bail		ie)	
C, Mall y and 2 shou Health and M tem 27 is man other traumat		19a. Informant's Name/Relationship (Type. Print) Ocena G. Snyder (Daught				<sup>and Number or Ru</sup> Drive Fal				Code)
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other	N.	20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Removal fror 4 ☐ Donation 5 ☐ Other (Specify)	n State		sition (Name of natory or other place Bap. Ce	1	Date 8-2009	20c. Location -	-	
permit. Departimorta any inji once.		21. Signature of Funeral Service Licensee	<u>-</u>		. Name and Addre	<sup>ss of Facility</sup> Scl MacPhail				of BelAir
Physician / Medical Examiner  by physician and burial-transit sthe burial-transit	23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Libease vir njury that initiated events resulting in death) Last  Due to (or as a consequence of):								Interval Between Onset and Death	
the death certification of the death certification of the death certification of the death of th	sician/Me	in the past 12 months?	utcome of pregnancy e birth 2  Fetal de gnant at time of deat known	ath 3 🗆	Ectopic pregnand Other (specify)				te of delive	ery Day Year
quires that the de	ed by Phys	Part II. Other significant conditions contributing to	death but not resultin							he cause of death?
i: The law requir	Completed	demistr					24a. Was autop perfo 1 □ Yes	osy rmed?	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
hysi this o	Certification: To Be	27. Manner of Death  TS Natural 5 Pending (Mo	onth, Day, Year)	b. Time of Injury	f 28c. Inju Wor M 1	26. Place of Dea her: 4 Nursing H ry at k?  Yes 2 No	ome 5 ☐ Resid	dence 6 □ Oth	red	(y) al Route Number,
ospital or A hours after ineral Directly y filled in by		29a. Certifier Certifying Physician: To t		dge, deatl	h occurred at the ti		City or Tov	vn, State) cause(s) and m	anner as s	stated.
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only one)  2 Medical Examiner: On the and more one)  29b. Signature and title of certifier	basis of examination anner stated.	and/or in	vestigation, in my			date and place, 29d. Date signe		
		30. Name and address of person who completed ca	use of death (Item 23	Ba) (Type,		255		Oul	7/7,	2009
Stat Registra		31. Date filed (Month, Day, Year) 32.	Registrar's Signature		28					

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4a, Pertalby Maryland Perpartment of Health and Mental Hygiene For

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturar", or items 23 a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at any Injury or other traumatic event, the Medical Examinat must be notified at ounce.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 13

	1 - State Registrar	$C\epsilon$	ertificate of Death	Reg. N	loc.	00104				
	1. Decedent's Name (First, Middle, Last)			2. Date of Death	No. Voor	3. Time of Death				
an	Marguerite Dolores Bosley	7		Month Cotober 1	Day Year .6, 2009	3:20 A. M				
ai	As Escility Name (If not institution, give street and num	hor)	4b. City, Town, or Location of Deat		c. County of Death	0.440				
er	4a. Facility Name (If not institution, give street and num	oei)				Country				
	231 Meadowvale <del>Drive</del>		Lutherville		Baltimore					
	4 🗆 14 0 🛱 E	'. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthi	place (State or Foreign ntry)				
	213-28-7474	78 Yrs.		June 13,1	.931   Balt	imore,MD.				
	Usual Residence of Decedent									
	10a. State 10b. County	10c. City, Town or			1	10d. Inside City Limits				
ᅙ	Maryland Baltimore County	/ Lutherv	ville			1 □ Yes 2 🖾 No				
ī.	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Cour	ntry?				
ā	231 Meadowvale Road		21093	Т	Jnited Sta	atres				
Completed by Funeral Director	10.111	15 : 110								
ű,	Armed Ford		<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	to Rican, etc.)	14. Race - Ameri Black, White,					
ΥF	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ If Yes, Give	5 MVo	1 ☐Yes 2 Hoo Specify:		Specify: W	nite				
q p	3 Widowed 4 Divorced Year or Da	es:	· · ·							
te	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	cedent's Usual Occupation	16b.	Kind of Business/In	dustry				
호	Elementary/Secondary (0-12) College (1-	4or 5+)	ve kind of work done during most of wo . DO NOT use retired)	g						
0	10 N/A	,	Contruction Coorid	nator	Telephone	e Company				
Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maid	en Surname)					
	William Silver		Mable K	azmaier						
မ	19a. Informant's Name/Relationship (Type. Print)	10h Ma			v or Town State Zi	n Code)				
		sband) 231	iling Address <i>(Street and Number of Ri</i> <b>Road</b> Meadowvale <del>Drave</del>	. Tud-bore	/ille,MD.	21.00.3				
13		, , , , ,								
. ^	20a. Method of Disposition	20b. Place of Dis cemetery, ci	position (Name of ematory or other place)		Location - City or To	own, State				
	1∑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	late   _	Mana Danala (CCC)	009' S	kesville,	Maryland				
	21. Signature of Funeral Service Licensee	\ A				C1 22 %				
8 8	1 - 201	M. B.	22. Name and Address of Facility Peaceful Alternati 2325 York Road T	ves Funeral imonium,Mar	&Crematic	on Ctr.,P.A. 21093				
		TO (1 C)			y.tana a	Approximate				
	23a. Part. Enter the discusse, or complications that ca shock, or heart failure. List only one cause on ea	ch line.		c or respiratory arrest,	. ]	Interval Between Onset and Death				
0	Immediate Cause (Final disease or condition resulting in death)									
	resulting in death)	r as a consequence of):				10 YEARS				
e e	Sequentially list conditions, if any, leading to immediate cause Enter Uncertains	r as a consequence of):								
Ë	Cause (Disease or injury									
xai	that initiated events c c	r as a consequence of):								
=		, , ,								
/Medical Examiner	d					<del></del>				
Je Je	IF FEMALE:									
	23b. Was decedent pregnant	ome of pregnancy rth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deliv	,				
ici ici	1 Dyes 2 Date 4 Pregn	ant at time of death	5 Other (specify)		Month	Day Year				
Physicia	9 Unknown 9 Unknown	wn								
<u>-</u>	Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?				
ð				1 ☐ Yes	2 No 3 Pro	bably 4 Unknown				
tec										
<u>-</u>				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of				
으										
dmo				performed	? death?	2 □No				
e Completed by	25. Was case referred to finedical		26. Place of De	performed 1 🗋 Yes 2 🗹	No 1 ☐ Yes	2 🗆 No				
Be	examiner?	instiant 2 \(\subset \in \subset \(\subset \subset \su	Other:	performed 1 □ Yes 2 ☑ ath (Check only e)	No   1 □ Yes					
Be	examiner? 1 Yes 20 No Hospital: 1 Ir	patient 2 ☐ ER/Outpal	ient 3 DOA Other: 4 Nursing I	performed 1 □Yes 2 ☑ ath (Check only e) Home 5 ☑ Residence	No   1 □ Yes					
Be	examiner? 1		of y 28c. Injury at Work?	performed 1 □ Yes 2 ☑ ath (Check only e)	No   1 □ Yes					
Be	examiner?  1  Yes	f Injury 28b. Time Injury Injury	itient 3 DOA Other: 4 Nursing I o of y M 28c. Injury at Work? 1 Yes 2 No	performed 1 □ Yes 2 ☑ ath (Check only e)  Home 5 ☑ Residence 28d. Describe how in	No	ify)				
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Medical Certification: To Be Comp	examiner?  1 Yes 2 No Hospital: 1 In Ir  27. Many of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physician: To the Der (Check only 2 Medical Examiner: On the be	f injury n, Day, Year)  28b. Time Injur  of Injury - At home, farm, g, etc. (Specify)  best of my knowledge, de sis of examination and/or	itient 3 DOA Other: 4 Nursing 1 28c. Injury at Work? M 1 Yes 2 No street, factory, office  eath occurred at the time, date and place investigation, in my opinion, death occurred at the time of the street investigation.	performed 1 Tyes 2 2 ath (Check only 9)  Home 5 PResidence 28d. Describe how in 28f. Location (Street City or Town, Strurred at the time, date 29d.	No   1 □ Yes  6 □ Other (Specially occurred)  and Number or Runate)  e(s) and manner as and place, and due  Date signed (Month	ral Route Number, stated. to the cause(s) , Day, Year)				
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ам Norma Jean Bland Oct<u>ober</u> 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center For Hospice Towson 8. Date of Birth (Month, Day, Ye Jan. 30, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F West Director 235 28 1129 1923 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland all Hygiene. d other than "natural", or items 23a or 28a-f show 10b. County 10c. City. Town or Location Direct 1 🗌 Yes 2 🄀 No Middle River Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 7 Tearose Drive 21220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event gines. 17. Father's Name (First, Middle, Last) ည Goldie Ferrell Oather Spencer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna McMillion (Daughter) 306 West Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 10/17/2009 Baltimore, Maryland 4 Donation 5 Other (Specify) <sup>22. Name and Address of Facility</sup> Bruzdzinski Funeral Home P.A 1407 Old Eastern Avenue Esse: 21. Signature of Funeral Service Licensee Maryland 21221 At 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congistive Physician/ disease or condition resulting in death) Medical Due to (or Sa a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? detached for 5 Other (specify) Month Day Pregnant at time of death 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MOS i 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has performed? Yes 2 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕅 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After 1. Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) October 14, 2009 12149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Touson, MD Sh 32. Registrar's 9 State Registrar

09-07	868
Allan	Branham

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 10, 2009 1032 hrs **Medical Examiner** Alan Randell Branham 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A 3031 Weaver Avenue Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Foreign 215-64-9313 Months Days Hours Min. Director Country) Maryland 1 X M 2 F 56 May 3, 1953 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland N/A Baltimore 1 X Yes 2 No notified at once. with the Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2920 Overland Avenue 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages I and 2 should be filed within 72 hours after death be Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item injury or other tranmatic event, the Medical Examiner must b 1 Never Married 2 Married Armed Forces? 2 X No Yes f Yes, Give Year Yes 2 X No specify: Specify: 3 Widowed Divorced White þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 SS**I**-Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harold Lee Branham Be Ethel Vada Dillard 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M Tina Marie Branham/Daughter 2920 Overland Avenue Baltimore Maryland 21214 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 10/15/09 Towson Maryland Donation 5 Other Specify 21 Signature of Funeral Service Licensee Name and Address of Facil inc. d Baltimore Maryland 21214 5305 Harford Road Approximate Interval 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line.

Torso injuries complicating methadone and alcohol Between Onset and /Medical Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f,permE, g896 10/21/09 TT attending physician for use as the burial -X UNPENDED AMENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Year Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ē ₫. Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' Yes 2 ✓ Yes No certificate To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: examiner? Other'4 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 Natural 1 Yes 2X No neral Director: filled in by the fi Pending 24 hours after death Fd 10/10/09 unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City Salor Town, State) 3031 Weaver Ave 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide To the Funeral D determined (Specify) found on ground Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only within 2 To the 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of cert October 11, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g899, 104, 104h and Mental Hygiene
Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** BISHOP DEMETRICK October 11:30 AM 13 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR HOSDITA Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F Yrs. Ü Director ne Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Completed by Funeral Director MOre 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23 0 5 items 23a 212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: ack 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 20191 City or Town, State, 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number 60' mother SSGA 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition bate permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 22 Name a neral 21. Signature of Funeral Service Licensee nd Address of Facility Service (as Cas 701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEHMONFA 7 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 7 days HlN1 Influenza Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by RENAC FAILURE 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2X No 2. No 1 ☐ Yes r this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: A 1 ☐ Yes 2 No investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October, 13 RES 000 erson who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 3001 South HANGUER Street, NikitA Pozderev MD 31. Date filed (Month, Day, Year OCT 1 6 2009 32. Registraris Signat State

DHMH 17 Rev 1/2001

Registrar

The law requires that the death certificate be executed physician and the burial-trans signed by the attending the detached for use as To the Hospital or Attending Physician: this certific al director, Director: 24 hours aft E Funeral Di within 24

**Physician** 

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

item 27 is marked other than "natural", or items 23a or other traumatic event, the Me iteal Examiner must be

Baltimore, Maryland 21215-0036

2 should be finance and Mental F

Pages 1 and 2 s ment of Health an ant: If item 27 is

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/Medical Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Completed by Physician/Medical as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be 25. Was case referred to medical examiner? 1 Yes 2 No ဥ 27. Manner of Death Certification: Natural 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MYSICIAN 10064533 Cicruarric 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W-BELTEBERE AVENUE BALTIMONE MD 21215 BARATUMDE

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year rowv 1005AM )a mice 2009 /Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore KosedaLe 9 Hare If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 6. \$ Birthplace (State or Foreign Country) (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F Months Year) 9, Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits, injury or other traumatic event, the Medical Exemplant Lugat be notified at Funeral Director 1 ☐ Yes 2 ☑ No da Se 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 00 21 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Bla Completed by If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO, NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other tha any injury or other traumatic event, the 100ce. tenogy 17. Father's Name (First, Middle, Last) Be mes BROWN, ( 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Rout Number, City or Town, State, Zip Code) gaugh Apt 203 BedROCK 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Durial 2 ☐ Cremation 4 Donation 5/ Other (Specify) 21. Signature of real Service Lio nsee 22. Name and Address of Facility 23a. Parti Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high artifailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C e (Final Physician ardiogenic disease or condition resulting in death) /Medical Duy to (or as a // sequence of): Examiner ardiomyopan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 No 1 ☐ Yes 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 4 hours after death. 2 Accident 1 ☐ Yes 2 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/13/09 50000 VIVIANA CUBELLOS

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State Registrar

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year,

Baltimore Maryland 21237

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** M RONALD LEROY BRADLEY SR **OCTOBER** 4, 2009 14:07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **™** M 2 □ F 224-36-3731 Director 75 July 12, 1934 Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Edgewood 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 137 Redbud Road 21040 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Styes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: 3 Widowed 4 Divorced "natural", Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ordinance Officer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fand Mental F 2 James Opalton Bradley Rose Juanita Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Bradley / wife 137 Redbud Road, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of h Department of Important; If it any injury or o 11-10-09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythmia Physician moved at disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dusease to Sequentially list conditions, france leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

State Registrar 29a, Certifier

29b. Signature and title of certifie

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son who completed cause of death (Item 23a) (Type, Print)

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1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicai Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D4223

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 8 P M Calvin Casey Birchum, Jr. October | 5:26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace Country)
April 22, 1957 Nevada 7. Age (In vrs. last birthday) **Funeral** Months Days 1 🕅 M 2 🗆 F Hours Yrs Director 530-54-2790 52 April Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 📆 No Directo Bethesda Maryland| Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 United States 10612 Montrose Avenue #104 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 □Yes 2X No Completed by Specify: Native American 3 ☐ Widowed 4 🙀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Instructional Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Calvin Casey Birchum, Sr. Delores Marie Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10612 Montrose Avenue #104, Bethesda, Maryland 20814 Lena E. Taylor / Fiancee 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 17, Schurz Cemetery Schurz, Nevada 2009 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850–2805 21. Signature of Funeral Service Licensee M01360 23a. Prt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** iva /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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Baltimore, Maryland 21215-0036

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Matthew Leonard, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifer

32. Registrar's Signature

D66896

Registrar

D66896

29d. Date signed (Month, Day, Year)

09-07926 Michael Cogan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 12, 2009 1148 hrs Medical Examiner Michael Cogan c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Somerset Peninsula Regional Medical Center Salisbury If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** oreign Months Days Hours Min. 06/21/1957 XM Director 164-44-4425 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State Yes 2 X No 23a or 28a-f show notified at once, Altoona Logan Township PA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 2254 East Pleasant Valley Blvd. 16601 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S Funera 11. Marital Status must be Armed Forces? 1 Never Married 2 Yes White 2 No specify: 4 X Divorced If Yes, Give Year Yes Specify: t. Pages 1 and 2 should be filed within 72 hours after trnent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Railroad MD 21215-0036 Crane Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marguerite Ferguson John Cogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 38 Overlook Pass, Enterprise, Alabama 36330 Rachel Showalter, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place)
Forsht Crematory Burial 2 X Cremation 3 Removal from State Altoona, Pennsylvania 10/27/2009 Donation 5 Other Specify 22. Name and Address of Facility Mauk & Yates Funeral Home, Inc T. Harman 21. Signature of Funeral Service Licensee 709 North Fourth Ave., Altoona, PA 16601 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death /Medical a. Head injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. If any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical 23a,PII,2/,28a-f,perME, g89/ 11/2/09 AMENDED X UNPENDED attending physician for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown र्व ALcohol intoxication Completed 24b. Were autopsy findings available page 2 should 24a. Was an peen autopsy prior to completion of cause of death? has performed? ✓ Yes 2 ✓ Yes certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be examiner? Other<sub>4</sub> Hospital: Residence 6 Other: Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA 1 🗸 Yes this ို funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Yes 2 X No subject fell To the nospossion within 24 hours after death.

To the Funeral Director: A 1 Natural Pending Fd 11:48 10/12/09 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 Carroll St Somerset, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide found on street determined Somerset, (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific October 13, 2009 O.C.M.E. Week 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Victor Weedn MD JD

State Registra

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and 4c. County of De **Examiner** 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace 5. Social Security Number **Funeral** Year) 212-44-560 Months Days Hours Min. 1 M 2□F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ty, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exemple: must be notified at 1 XYes 2 □ No Director 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White 16. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 No ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry College (1-4or 5+) ekeeper 27 is marked other 18 Mother's Name (First, Middle, s Name (First, Middle, Last Be PNOF 19b. Mailing Address (Street and Number or Pural Route Number State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troonce. 20b. Place of Disposition (Nat cemetery, crematory or 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service Ligensee MILLER Approximate Interval Between Onset and Death Enter to isease, or complications that caused the death. failure. List only ause on 3 ch line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Im negrate Cause (Final di lea e or condition rest ting in death) **Physician** noor /Medical Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events and the conditions of the conditi Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Division of Vital Records, P.O, Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Day 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day, Year) Time of Injury 27. Manner of De 28c. Injury at Work? 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No Director: 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated.

the Hospital or Attending Physician: completely filled in by the funeral director. within 24 hours a

> 30. Name and address of cause of ath (Item 23a) (Type, Print) Registrar

29b. Signature

and title of certifie

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death **Physician** awson 200 tobe /Medical 4a. Facility Name (If not institution, give street and number) Aity, Town, or Location of Death **Examiner** S HOS nwes MOV 8. Date of Birth Social Security Number (In yes last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age 9, Bir **Funeral** 1□ M 2 🗹 F Months Days Hours Min Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic every any injury or other traumatic every many. 10b. County wn or Location 10d. Inside City Limits 1 Nes 2 No Funeral Director no Ke 10e. Str et and Numbe 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 Never Married 2 Married 1 ∐Yes 2 ZNo If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 □ Divorced ac 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life—DG-NOT use retired) Element ndary (0-12) College (1-4or 5+) Name (Figst, Middle, Last) 18. Mother's Name (First, Middle, M Be ပ A Rural Route Numb 19b. Mailing Addres Place of Disposition (Nam cemetery, crematory or of 20a. Method of Disposition 2 Cremation 3 Removal from State 5 ☐ Other (Specify) uneral Service Licenses Pa. 1. Enter the disease, or complications that caused the death. nock, or head failure. List only one couse on each line. 23 . Pa 1. Enter the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Imprediate Cause (Final Isease or condition resulting in death) set and Death **Physician** lase /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☑No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has l irector, page 2 s autopsy performe 1 □ Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 K ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. 28d. Describe how injury occurred injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number e and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Me

nth, Day,

31. Date filed (Month

DHMH 17 Rev 1/2001

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registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** October 2:30 Frances Rey Case /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Baltimore Washington Medical Ctr Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 M 2 X F Hours 212-34-6530 **Director** 08/04/1934 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Funeral Director Anne Arundel Glen Burnie 1 ¥Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7466 Furnace Branch Road 21060 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2 XNo Specify Completed by 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home other Maryland Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filt trent of Health and Mental Hant: If item 27 Is marked oth Jury or other traumatic even Frank Connell Grace May Lowman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 Dales Way Drive, Pasadena, MD 21122 19a. Informant's Name/Relationship (Type. Print) Kenneth Case/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page: Department of Important: If any Injury or once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Cremation Services | 10/16/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services Lama C. Hardesty 7522 Connelley Drive, Ste.N, Hanover, MD 21076 M01197 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner was Sequentially list conditions, if any leading to him reduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown nis certificate has been signed by i director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical and manner stated. 29c. License number 0 4 13 6 5 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

OCT 16 2009

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30. Name and address of person who completed pause of death (Item 25a) (Type, Print) HOSPITAL Drive, Gen Burnis, 2016

09-07866 Peter Curtin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day October 10, 2009 1311 brs Medical Examiner Peter Norman Curtin 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Union Memorial Hospital Baltimore If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Min. Days Hours Months Director Country) 136-80-5085 23 1 X M 2 24 1986 Usual Residence of Decedent 10d. Inside City Limits City, Town or Location 10a. State Wilmington Hanover 1 X Yes 2 No Cambridge MA Middlesex hours after death with the Maryland Director 10g. Citizen of What Country 10e Street and Number 4819 Whitner Drive 10f. Zip. Code 28409 <del>88 Hancock Street</del> USA 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. must be White, etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes or White Yes 2 X No specify: Divorced If Yes, Give Year Specify. Widowed l other than "natural", the Medical Examiner "natural", ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "' injury or other traumatic event, the Medical E MD 21215-0036 Graduate School 5+ Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne Bodine Michael Joseph Curtin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4819 Whitner Drive., Wilmington, NC 28409 Michael Joseph Curtin, Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore. crematory or other place) Burial 2 X Cremation 3 Removal from State Andrews Crematory 10/14/09 Donation 5 Other Specify: Wilmington, NC <sup>22</sup> Name and Address of E<sup>acill</sup>inc. 5305 Harford Road Baltimore Maryland 21214 21-Signature of Funeral Service Licensee Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Cardiac arrhythmia Immediate Cause (Final disease) kaminer or condition resulting in death) Due to (or as a consequence of): b accessory nodoventricular conduction pathway of heart Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical #10a-c,e,f,perFH,G898,12/18/09,WS X UNPENDED attending physician for use as the burial line a-b, 27, permE. g897 Box 68760. 23d. Date of delivery IE FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Linknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been si 2 should b 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No certificate the Hospital or Attending Physician: 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be Hospital: 1 Other: examiner? Inpatient 2 V ER/Outpatient 3 Nursina Home 5 Residence 6 this 1 🗸 Yes 2 After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 Director: d in by the 1 Pending 24 hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) within 24 hours at To the Funeral D determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) October 11, 2009 O.C.M.E. 30. Name and address of perion who completed cause of death (Item 23a) Deputy Chief Medical Examiner Jack Titus MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State arket Registra 01

			, FOF	State of Marylan				Mental Hyg	jiene	
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Cei	tificate of l	Jeath	2. Date of Deat	eg. No.	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death	′ 0	4c. County of Dea	h
~			5. Social Security Number 6. Sex	7. Age (In yrs. I	ast hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
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	arylar show	<u>_</u>	10a. State 10b. County Maryland Anne Arus		, Town or Lo Len Bui					10d. Inside City Limits 1 □ Yes 2 □ No
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	aa or	Ö	123 Glen Road			21060			USA	······ <b>,</b> ·
	death	Funeral		. Was Decedent Ever in U.S	S. 13. \	Vas Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race - Ame	
9	be filed within 72 hours after death with the Maryland Hygiene.  ad other than "natural", or items 23a or 28a-f show event, I're I saficial Examir er must be notified at	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give		TYes, specify Cuba □Yes 2⊠No	Specify:	o Rican, etc.)	Black, White	e, etc. White
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<u>ya</u>	should be f and Mental I s marked of umatic eve	2	unknown				Marion		Jones	
Maryland			19a. Informant's Name/Relationship (Type Donlad J Collins J	,	1	-			r, City or Town, State, . S City VA 2	
ā,	es f and 2 of Health a f item 27 Is r other tra		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other plac	·a)	Date	20c. Location - City or	Town, State
altimore,	Pages ment of ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		ematory :	i	9/2009	Baltimore	Maryland
gar	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	1	100	. Name and Addres	5	_	Funeral Ho	
	44 2 % G		23a, Part 1, Enter the divease, or complica	tions that caused the death					na MD 21122 rest.	Approximate Interval Between
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XOX .	certif nding use as	√/Me	IF FEMALE: 23b. Was decedent pregnant 23c	:. If yes, outcome of pregna	ncy				23d. Date of de	livery
ň	death e atte d for u	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d		Ectopic pregnanc; Other (specify) _	у		Month	Day Year
יי כ	at the 1 by th stache	hys	9 ☐ Unknown	9 🗆 Unknown						
gg.	signec	þ	Part II. Other significant conditions contri	buting to death but not resu	ilting in the ur	iderlying cause give	en in Part I.	23e. Did tol	bacco use contribute t es 2 🎇 o 3 ☐ P	robably 4 Unknown
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DIVISION	after after Direct of in by	Certification: To	4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, iaim, sire	eet, lactory, office		City or Town	treet and Number or R n, State)	urai noute Number,
	to the hospital or Attending Prostcian: The law requires that the death certin within 24 hours after death. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical Examine	cian: To the best of my kno r: On the basis of examina						
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			30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print)	- 1	-9	70/81	
			31. Date filed (Month, Day, Year)	32. Registrar's Signar	T P	695	Hm	erica	+ 2103	5 5
	Sta Registr		OCT 16 2009	a. negistrars digital	Mari	Continue de la contin				

Box 68760, P.O. Division of Vital Records,

within 24 hours a

State Registrar 29a. Certifier

29b. Signature and title of certifier

Medical

31. Date filed (Month, Day, Year)

n'on - Door



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carroll Physician/ 11:50 a<sub>M</sub> Richard Warren 0ctober 1<sup>a</sup>5 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours eb 21, 1935 Months 215-32-2521 74 Marv1and Director Yrs Usual Residence of Decedent 28a-f sho 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Towson Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21286 1203 Providence Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Automotive Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Evelyn Mattes John Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Debra Carroll/ Daughter 1203 Providence Rd. Towson, Md. 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 10-20-09 |Owings Mills, Md. Garrison Forest Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Ruck of Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic melanoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury) that initiated events. Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ been signed by the atteraction should be detached for in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an as Se prior to completion of cause of death? certificate ha lirector, page 2 performed? Yes 2 X No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Hospital Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🖾 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R149194

MD

Towson,

October 15,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Deceden s Name (First, Middle, Last) **Physician** 2009 /Medical give street and number ty of Death Facility Name (If not institution Town, or Location of Death **Examiner** Istour Andal Pice easons 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Birthplace (State or Foreign Funeral Months Days Hours 12 M 2□ F -40-054 CAVE line Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Midian 1 Never Married 2 Married 1 □Yes 2 1 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DONGFuse utiled) College (1-4or 5+) Elementary/Secondary (0-12) 17 Father's Name (First Middle, Last) (First, Middle, Maiden Surpa AUIS Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Stre Department of Health Important: If item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1⊠Burial 2 □ Cremation 3 □ Removal from State 2009 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address any Approximate Interval Between Onset and Death 23a. Part1. Enta he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest pmediate Cause (Final isease or condition resulting in death) Gastnic Physician Metastatic Carcinomo /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 **1**000 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? 6 Dother (Specify) + hospice Other: 2 No 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \Bull Nursing Home Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural within 24 hours are control to the Funeral Director: A/ 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MS Rajapakse MID 10/11/09

State Registra

DHMH 17 Rev 1/2001

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25 Main

32. Restrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D.

31. Date filed (Month, Day, Year)

D0057465

200, Reisterstown, MD, 21136

# OCTOBER 13, 2009 4:34 p.m. Baltimore, Maryland 21215-0036

MARY DEAN ion of Vital Records, P.O. Box 68760

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036 s after death value, or items Examiner mu	by Eur	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3※Avidowed 4 ☐ Divorced	Armed Forces?		l1	Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White	rican Indian, e, etc.
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hydgiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami	ł	2	1 🖾 Burial 2 🗆 Cremation 3 🗀		20b. Pi	ace of Dispo metery, cren Laney Menoria	sition <i>(Name of</i> natory or other place Valley al Garden	octo 16,			•	
Balt permit. Departi	ouce.		21. Signature of Foneral Service Licens			Per	aceful <sup>Addre</sup>	terriative	es Fune: imonium,	cal Ma	&Cremat	ion Ctr.,P.A 21093
Physicia:	n/		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line						est,		Approximate Interval Between Onset and Death
Medic	al		resulting in death)	a. CHRUNI  Due to (or as a	consequ	ence of):	LVE PULMO	NAKY DISI	EASE			
The Tree of the state of the st	aminer		If any, heading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Diss to (or es a	Оствеци	ence off						
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Box 68 e death certifi the attending hed for use as	vsician/	y sicilar		1 Live Birth	2 🗌 Fetal	death 3 [		У			23d. Date of del Month	ivery Day Year
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director. After this certificate has been signed by the funeral director, page 2 should be detact	2	<u>'</u>	Part II. Other significant conditions co	ntributing to death bu	ut not resu	ilting in the u	nderlying cause give	en in Part I.				
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the Hospi nin 24 hou the Funer npleted fil		(Check 2 Medical Examination only one) 3 Certifying Nurs	ner: On the basis of ex	amination	and/or invest	igation, in my opinion leath occurred at the	n, death occurred at time, date and plac	t the time, date a ce, and due to the	nd place cause(s	e, and due to the o s) and manner as	cause(s) and manner stated. stated.	
witi		2	Certificate of Death  Mary Lucille Cagliano Dean  Mary Lucille Cagliano Dean  Mary Lucille Cagliano Dean  Accompany for seather, so year and an arrived and number of the process of the p									
5	Physician Mercy Luci I I Capital Company and the company and t											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** uBose 09 415 М 3 Iliam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ehaba Extended Can Center Baltimore 8. Date of Birth (Month, Day, Year) NOV • 14, 1951 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min 1415 M 2□ F 57 056-44-6061 Director Bronx, New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, Ite Marical Examinating must be reliting at any injury or other traumatic event, Ite Marical Examinating must be reliting at any once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore County Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country?
UNITED States 10f. Zip Code 5615 Cynthia Terrace 21206 of America Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2,⊠No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter Sun Decks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ William DuBose Alma Robinson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,\,21213$ sister Mrs. Brenda C. DuBose-Coleman/ 1401 North Lakewood Avenue Apt. 232 Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest
Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State October 23 Burial 2 Cremation 3 Removal from State Garrison, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 ter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Part 1. Z Immediate ause (Fin I disease or condition resulting in death) **Physician** Carcinoma Hepatocellular /Medical Due (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 | Yes 2 | No 3 | Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy certificate 2 🗆 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

nab Extended Care Center, Baltimore, MD 21218

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DCTOBER 11:50PM Delbra Dupree 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2 🕶 F Days Months Hours 217-76-0948 N. Carolina Feb 4, 1957 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 21239 USA -IN WORTH Ave 2B 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church  $\bigcirc$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ray von Everette Janue Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linworth Are Baltimme Mp 21239 Parker MONICA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MT Zion Oct 16,2009 | LANdsdown, Wkingland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Renald A. Graysan Funeral Service
270 FREDHILL Pass Balomo 21229 21. Signature of Funeral Service Licensee -brald a Graym 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTISYSTEM ORGAN FAILURE 10 HOURS disease or condition resulting in death) Due to (or as a consequence of) 24 HOURS SEPTIC SHOCK Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ESCHERICHIA COLI BACTEREMIA UNKNOWN Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 □ No 1 Yes 2 □ No 26. Place of Death (Check only one) Hospital:

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

Show

Director

Funeral

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Completed

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r than "natural", or items 23a or 28a-f shov the Medical Examiner must be redified at

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permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and injury or other trau

Baltimore, Maryland 21215-0036

the death certificate be executed burial Box 68760, attending physician for use as the buria the as P.0. ģ signed by Records,

Division of Vital

Physician:

or Attending

To the Hospital

within 24 hou To the Fune completely fi

page 2 certificate After this certific funeral director, thours after death.

uneral Director: Aftely filled in by the fun the Funeral Directory filled in by

Physician/Medical

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Completed

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NEUTROPENIA POSSIBLE MYELODYSPLASTIC SYNDROME DIABETES MELLITUS 25. Was case referred to medical examiner' Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

THERESA NICOL 31. Date filed (Month, Day, OCT 16

7621 OSL ER DRIVE 32. Registrar's Signature

M. D

1con\_

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DØØ47638

TOWSON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d, per MD G897 11/2/09 TT

Amend 29d, State of Maryland (Department of Health and Mental Hygiene

	1 - For State Registrar	State of Maryla		artment of H rtificate of L		nd Mental Hy	giene Reg. No.	2000	0015
sician	1. Decedent's Name (First, Middle, Last, Jerome Arthur Don					2. Date of De Month October	eath Day	Year	3. Time of Death 11:10 A M
edical miner	4a. Facility Name (If not institution, give Suburban Hospital	street and number)		4b. City, Town, or Bethesd	la	Death	4c. 0	County of Deat	ry
ral tor	5. Social Security Number  101-30-0856  Usual Residence of Decedent	T. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		Min. B. Date of Bi (Month, D	rth ay, Yea <i>r)</i> <b>21, 19</b>	Co	hplace (State or Foreiguntry) W York
ctor	10a. State 10b. County  Maryland Montgom		ity, Town or Lo						10d. Inside City Limit
Directo	10e. Street and Number			10f. Zip Code				en of What Co	-
To Be Completed by Funeral Director	8525 Thornden Ter  11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		20817 Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🏋 No	ispanic Origi n, Mexican, I Specify:	n? (Specify Yes or N	o- 1-	ed Stat  4. Race - Ame Black, White  Specify: White	rican Indian, e, etc.
Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 5+	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most o )	f working	Dept	of Business/ c. of H n Serv:	ealth and
To Be C	17. Father's Name (First, Middle, Last)  John Vincent Don1				Mary	Name (First, Middle Teresa No	rton		
	19a. Informant's Name/Relationship (Ty Mildred Anne Don1					or Rural Route Numl ace Bethe			
	20a. Method of Disposition  1 Burial 2 X Cremation 3 F 4 Donation 5 Other (Specify)	20b. Removal from State M.C.	Place of Dispo cemetery, crei	sition (Name of		tober 16,	20c. Loc	cation - City or	
<del>once</del> .	21. Signature of Funeral Service dicens	96 / J	RO RO	2. Name and Address	s of Facility		Rethes	:da-Chevv	Chase, Inc.
n al	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the dea ne cause on each line.  Brain Tumon Due to (or as a conse	r	ter the mode of dyin	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death 3 Months
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.							
sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐ Ectopic pregnancy	/		2:	3d. Date of de Month	ivery Day Year
ed by Phys	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.				o the cause of death?
Completed						24a. Was auto perf 1 🗆 Yes		prior to death?	utopsy findings availab completion of cause o : 2 □ No
o Be	25. Was case referred to medical examiner?  1 Yes 2 XNo	lospital: 1 ☐ Inpatient 2	Ď ER/Outpatie	nt 3 🗆 DOA Othe	Dr.	f Death (Check only ing Home 5 ☐ Res		□Other (Spa	oifu)
Certification: To	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Injury Work M 1 🗆		28d. Describe			//
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec				City or To	wn, State)		ural Route Number,
Medical	(Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examin and manner stated.		vestigation, in my o	pinion, death		, date and	place, and due	e to the cause(s)
2	29b. Signature and title of certifier	ndl		29c. License D672			Octo	ber 14 mber 1 mber 1	,
State	30. Name and address of person who con Nicholas Farrell, 31. Date filed (Month, Day, Year)		dical (		ive #3	00, Rockv			

			For State Registrar	State of I	Marylar		artment of rtificate o		and M		giene Reg. No. 🥬	100	+ ) = 1 = 1	153
	Physic		1. Decedent's Name (First, Middle, La	-	seph	Domini	c Duga	n		2. Date of Dea Month October	ath 13,	20 <sup>v</sup> 69	3. Time of 9:45	Death A M
	/Medi Exami		4a. Facility Name (If not institution, gi	ırt			4b. City, Town	, or Location o	of Death		4c. Co Mor	unty of Deatl	ry	
	Funeral Director		5. Social Security Number 058-12-9912  Usual Residence of Decedent	Sex 7 1 M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birt (Month, Da <b>January</b>	21 <b>,</b> 192	9. Birti Con New	nplace (State o untry) York	r Foreign
projection of	28a-f show	Director	10a. State 10b. County  Maryland Montgo	mery	10c. Ci	ty, Town or Lo	sda						10d. Inside Cit	
t dith	23a or 2		10e. Street and Number 13 Savannah Cour	't			10f. Zip Code	∍ 20817				n of What Cou ted Sta	•	
5-0036	or incomming a trious area boarn with the interval year and Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the short control of the co	by Funeral	11. Marital Status 1 □ Never Married 2 💆 Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2[ If Yes, Give Year or Date	s? ⊒No WW:	II '	Vas Decedent of fYes, specify C			cify Yes or No- Rican, etc.)		Race - Amer Black, White pecify: W		
21215-(	ene. than "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-40	or 5+)	(Give life. L	lent's Usual Occ kind of work dor DO NOT use reti autical	ne during most ired)		g		of Business/I	ndustry Vernmen	+
belled	is marked other is anamatic event, the	To Be Co	17. Father's Name (First, Middle, Last John Dugan	<u> </u>		Heron	aucicai	18. Mothe		(First, Middle, alsh			vernmen	L
, Mar	ealth and n 27 is m		19a. Informant's Name/Relationship Frances Dugan Bat		hter	,	g Address <i>(Stre</i> vannah							
limore Pages 1	Department of Health and Mentile Important: If item 27 is marked any injury or other traumatic enonce.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	te C	cemetery, cren	sition (Name of natory or other p rematoriu		ctobe 2009	ř 15,		ion-City or T esda,	own, State Mary1an	ıd
Ball	Depart Import any in	v	21. Signature of Funeral Service Lice	aut	M0130							le, Inc aryland	20850–2	805
	nysician /Medical	0 10	23a. Part 1. Effer the disease, or com shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Chron	line.	struct	ive Pul				rest,	1	Approximate Interval Betwoen Onset and D	Death
	xaminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	tensi					_		]	0 Year	S
<b>8760</b> , <sup>7</sup> Cate be execu	physician and s the burial-transit	dical	that initiated events resulting in death) Last	CDue to (or a	as a conseq	uence of):								
P.O. Box 6 that the death certific	after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	n 2 ☐ Feta tat time of c	ldeath 3 ⊑	Ectopic pregnal Other (specify)				23d.	. Date of deli	•	'ear
rds, P	s been signed t	٥	Part II. Other significant conditions	contributing to death	but not resi	ulting in the un	derlying cause (	given in Part I.					the cause of de	
Division of Vital Records, Lor Attending Physician: The law requires the	his certificate has be I director, page 2 sho	e Completed	25. Was case referred to medical					OC Disease	-f D-ath		sy med? 2 No	prior to codeath?	opsy findings a completion of ca	ivailable tuse of
of Vi	this cer al direct	To Be	examiner? 1 ∐ Yes 2 📉 No	Hospital: 1 ☐ Inpa	itient 2 🗆	ER/Outpatien	3 □ DOA C	other: 4 🗆 Nui		<i>(Check only or</i> e 5 <b>X</b> Resid		Other (Spec	ify)	
Sion (	ter death. irector: After thi n by the funeral o	Certification: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not b	1	Day, Year)	28b. Time of Injury	28c. In W M 1	juryat ork? □Yes 2□N	28	3d. Describe h				
Divi	urs after o	- 1	4 ☐ Homicide determined	building,	etc. (Specif	y)	et, factory, office			City or Tow	n, State)		al Route Numb	oer,
he Hosp	within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one)  1 ⚠ Certifying Pr 2 ☐ Medical Exar	nysician: To the bes niner: On the basis and manner:	of examina	wledge, death tion and/or inv	occurred at the estigation, in m	time, date and y opinion, deat	d place, ar th occurred	nd due to the o	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)	
Tot	with To t	Σ	29b. Signature and title of certifier  W	M - 1).			29c. Lice	nse number	-	2		<sub>gned (Month</sub> ber 14		
18	140		30. Name and address of person who Warren O. Ferris			, , , , ,	eisure V	lor1d B	lvd.	. Silve	r Snr	ine. M	arvland	120906
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 1 6 2009	32. Regis	strar's Signa		V			,	PL			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ivial			or nearm and of Death		giene Reg. No.	
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Dea Month	th Day Ye	3. Time of Death
way	/Medic Examir	cal	4a. Facility Name (If not institution, give	lice Virgi	nia Disne		own, or Location of Dea		er 13, 200	09  8:03PM <sup>™</sup>
, , ) 	CXAIIIII	lei	Shady Grove Ad	,	spital	la ony	Rockvil		1	ntgomery
	Funeral		Social Security Number     6. Se		(In yrs. last birthday)	If Under 1 Months		8. Date of Birth (Month, Day	y, Year) 9.	Birthplace (State or Foreign Country)
	Director		579-48-4048 Usual Residence of Decedent		74 Yrs.	l		December	31, 1934	Maryland
	ıryland show	_	10a. State 10b. County	1	I Oc. City, Town or Lo	cation				10d. Inside City Limits
	he Ma 28a-f	Director	Maryland Montg	omery		Trace and a	Rockville			1 X Yes 2 □ No
	Sa or	i Dir	10e. Street and Number	oln Street		10f. Zip 0			log. Citizen of What	
	death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decede	20850 ent of Hispanic Origin? (i fy Cuban, Mexican, Puel	Specify Yes or No-	14. Race - A	ed States American Indian,
36	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or items 23a or 28a-f show event, it as Medical Eventral neat be restlined at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ី Divorced	1 ∐Yes 2 X No If Yes, Give		il Tes, specii 1 ∐Yes 2.		to nican, etc.)	Specify:	/hite, etc.
21215-0036	2 hour	ted t	15. Decedent's Edu	Year or Dates: cation	16a. Dece	dent's Usual	Occupation		16b. Kind of Busine	White ess/Industry
215	within 7% iene. than "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done during most of wo	orking		,
121	filed wi Hygier ther th		12			Insu	rance Clerk			rance
Maryland	ed stal	o Be	17. Father's Name (First, Middle, Last)	h Carrol T	roil		18. Mother's Na	me (First, Middle,	,	1
aryl	she and and and and and and and and and and	2	19a. Informant's Name/Relationship (T)			ng Address (	Street and Number or R		$\mathtt{ret} \ L$ . Per $r$ , City or Town, State	
	こうべ -		Mark Wayne Disney/	Son	8112	Arrow	head Court	Frederic	k, Maryla	nd 21702
Baltimore,	0 0 ± 5		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ F		20b. Place of Dispo cemetery, cren	sition (Name natory or oth	e of per place)	Date	20c. Location - City	or Town, State
ij	# 본 원 중 .		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fuperal Service Licens		Rockville	e Ceme	tery 19,	ober 2009	Rockvil	le, Maryland
ä	Depared Important Importan		1 2		00335 Ro	ockvil ockvil	le, Inc. 30 le, Marylar	00 West M nd 20850-	ontgomery 2805	Funeral Home/ Avenue
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the cause on each line.	e death. Do not ent	er the mode	of dying, such as cardia	c or respiratory arr	rest,	Approximate Interval Between
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Pulmonary	Arres	t			Onset and Death
7	Examiner			·	consequence of):		4.4 D. 1	Diameter Diameter	2020	
4	p #=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of):	Struc	tive Pulmor	ary Dise	ase	
D	rificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Renal Fa						
68760,	e be e sician s buria			Due to (or as a c	onsequence or.					
687		Medical		·					-1	
Вох	death cer e attendir id for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	pregnancy □ Fetal death 3 □	Ectopic pre	gnancy		23d. Date of	
_ •	ires that the death ce signed by the attendir I be detached for use	Physician/	1 Yes 2 No 9 🖾 Unknown	4 ☐ Pregnant at tii 9 ☐ Unknown	me of death 5	Other (spec	cify)		Month	Day Year
σ.	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detache	by Ph	Part II. Other significant conditions col	tributing to death but r	not resulting in the ur	nderlying cau	ıse given in Part I.	23e. Did tol	bacco use contribut	e to the cause of death?
Vital Records,	w require: s been sig should be	ed b						1 □ Ye	es 2□No 3□	Probably 4X Unknown
Sec.	e law r has be je 2 sho	Completed						24a. Was a	n 24b. Were	autopsy findings available to completion of cause of
a F	ician: The l certificate ha							perform 1 □ Yes	ned? deatl 2 <b>X</b> No 1 □	n? Yes 2□No
₹ :	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	lospital:	2 ☐ ER/Outpatien	+ 2 T DOA	T	ath (Check only on		
	ding Phy h. After thi funeral c	n. T	27. Manner of Death	28a. Date of Injury (Month, Day, Y	28b. Time of		c. Injury at Work?	1	ence 6 Other (Sow injury occurred	Specify)
Sio	Attending er death. rector: After by the funer	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	- (monus, buy, s	Car, Injury	М	1 ☐ Yes 2 ☐ No			
Division		Certification: T	4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, stre (Specify)	eet, factory, c	office	28f. Location (Si City or Town	treet and Number of n, State)	r Rural Route Number,
_ :	Hospita 24 hours Funeral stely fillec		29a. Certifier 1 Certifying Physics	sician: To the best of r	my knowledge, death	occurred at	t the time, date and place	e, and due to the c	ause(s) and manne	r as stated.
		Medical	one) 2 Medical Exami	ner: On the basis of ex and manner state	kamination and/or inv	estigation, i	n my opinion, death occ	urred at the time, d	ate and place, and	due to the cause(s)
	To the within To the comple	2	29b. Signature and title of certifier	av	mn	29c. I	License number	2	9d. Date signed (M	onth, Day, Year)
	10	-	30. Name and address of person who co	mpleted cause of deat	th (Item 23a) (Type, F	Print)	D67512		Octobe:	r 14, 2009
	V		Madan Bangalore, M	.D. 9901 M	ledical Ce		Orive_Rockv	ille. Man	ryland 208	350
	Stat		31. Date filed (Month, Day, Year)	32. Pegistrar's	Signature.	add		-		

			For State Registrar	State of	Marylar	-		nt of H te of D		nd Mental	Hygiei Reg.	2 1111	9 93155
	Physicia Medic		1. Decedent's Name (First, Middle Rodger	Evans	Dox	sey				2. Date of Mont		3°, 2009°°	3. Time of Death 7:40 p M
	Examir		4a. Facility Name (if not institution Gilchrist	, give street and numb	per)		4b. City		Location of	Death		4c. County of De Baltin	
	Funeral Director		5. Social Security Number 295-46-0324	6. Sex 1 🔀 M 2 □ F	7. Age (In yrs. 1	.,	If Und Months	er 1 Year Days	If Under 24 Hours	Hrs. 8. Date of Mont	of Birth b, Day, Yes	947 N	Birthplace (State or Foreign
	Maryland 28a-f show otified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD Ba	ltimore	10c. Cit	ty, Town or Lo	cation VSON						10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	with the 23a or 1st be no	eral Di	10e. Street and Number 1506 Jeffers	Road	•		10f. Z	p Code 21204	4		10g.	Citizen of What U.S	Country?
90036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status  1 ☑ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ☐ Divorcec	If Year China	ces? 2 🕱 No		f Yes, spe	ecify Cubar 2 🙀 No	Specify:	n? (Specify Yes or Puerto Rican, etc	.)	Black, Wh	lhite
21215-0036	within 72 he giene. er than "na et the Medic	Comple		college (1-4	1 or 5+)	life. D	kind of w	ork done di se retired)	ition uring most o	f working	16b	o. Kind of Busines Hubbl Space	
Maryland	should be filed within and Mental Hygiene. 'is marked other tha 'aumatic event, the N	To Be	17. Father's Name (First, Middle, I	,	xsey					s Name <i>(First, Mi</i> ) <b>orothea</b>	ddle, Maid		ertnik
, Man	nd 2 shoul salth and t n 27 is ma er traums		19a. Informant's Name/Relations Vicky Balzano		•					or Rural Route No		or Town, State, 2 21204	Zip Code)
Baltimore,	Page 1 ar nent of He ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S		State	Place of Dispo cemetery, crem 1top Se	natory or	other place		Date 0/19/09		Location - City	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service I	icenseeWillia	m G. Da	au 22				Ruck Tow Towson		Funeral 21204	Home, Inc.
	Physician/ Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each	h line.	c Colo				rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death
00	cate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (o	r as a consequ	uence of):							
. Box 68760	ath certifi attending for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 🗀 Feta ant at time of	al death 3	Ectopic Other (s		,			23d. Date of o	lelivery Day Year
s, P.O.	requires that the de been signed by the should be detached	d by PI	Part II. Other significant condition	ons contributing to dea	ath but not res	sulting in the u	nderlying	cause give	en in Part I.			- 6	to the cause of death?
Division of Vital Records,	The law requ ate has been page 2 shoul	Completed by									Was an autopsy performed Yes 2 🔀	prior to death?	autopsy findings available completion of cause of
Vital	hysician: The law nis certificate has t I director, page 2 s	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2 🗆	ER/Outpatier	nt 3 🗆 E	Other		(Check only one)			ecity) hospice
on of	nding Physath. r: After this e funeral di		27. Manner of Death  1 X Natural 5 Pendir 2 Accident Investi	28a. Date of (Month		28b. Time of injury		28c. Injury work?	at	28d. Descr		jury occurred	Striyy . The strip of the strip
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Il Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place o	f Injury - At ho g, etc. (Specify	ome, farm, stre	eet, facto	y, office			on (Street Town, Sta		ural Route Number,
,D	he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2 L Medical E	Physician: To the best examiner: On the basis Nurse Practioner: To	of examination	n and/or invest	igation, ir	my opinior	, death occu	irred at the time, o	ate and pla	ace, and due to the	e cause(s) and manner stated.
10	To t To t		29b. Signature and title of certifier  Man Le					c. License 21491				Date signed (Mon	
			30. Name and address of person Marian Grant	(,701 N.	Charles	s St.	Tou	Son,	MD	21204			
	Stat Registra	e ir	31. Date filed (Month, Day, Year) <b>OCT 1 6 200</b>	32. Reg	gistrar's Signa	ture	9						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12<u>,</u> October Y09 **Physician** Albert Easter /Medical Ctn. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Summit Park Health & Rehab. Baltimore 5. Social Security Number 6. Sex XXM 2□ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10-13-9. Birthplace (State or Foreign Country) VA 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 230-56-4315 63 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examination must be notified at Director Prince George VA Hopewell 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2011 Luther Blvd. USA 23860 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. X Never Married 2 ☐ Married Easter Maryland 21215-0036 Health and Mental Hygiene. em 27 is marked other than "natural", or i 1 □Yes 2 No Specify: Specify:American þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse J. Easter Gertrude 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau 2011 Luther Blvd. Hopewell, VA 23860

of Disposition (Name of Date 20c. Location - City or Town, State Clarence Easter-Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 10-19-09 Prince George, VA Mt. Sinai Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final IRACT UR INDAKY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to him electroause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown has been signed by le 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy autops, performed? Yes 2 Wo certificate 1 ☐ Yes 1 ☐ Yes tor: After this certific the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ANO Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

11:15P M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

2 ANO

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 No

African

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital To the I

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Quaino HD

32. Registrar's Signature

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

20X01765

3350 Wilkens Ave . #307 Bollimre Hosle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ o to ber 17:10 PM rauna 2009 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Bayview Medical Center Baltimore Johns N/ASocial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F (Month, Day, JUL 30 Year) 1961 MARYLAND Director 217-80-3327 48 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1XXYes 2 No BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21234 1332 DEANWOOD RD. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. POSTAL SERVICE POSTAL CLERK 4yrs 12yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Hitem 27 is marked of မ VIOLA HULL JACK EULLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1332 Deanwood Rd., Baltimore, Maryland 21234 Renee Davis/Sister : If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State þ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: It any injury of LANSDOWNE, MARYLAND MT. ZION CEMETERY 10-20-09 4 Donation 5 Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE Tall 1. Enter the disease, or omplications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onse and Death Immediate Cause (Final Pulmonary Embolism Physician/ disease or condition resulting in death) day Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 횬 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. Ineral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be

or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Division of Vital Records, within 24 hours a the Hospital

> State Registrar

filled in by

Medical

4 Homicide

29a. Certifier

(Check

James

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 0CT 16 2009

determined

Tabibian

4940

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ted cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Eastern Avenue Baltimore, MP 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** ICHELBERGER 2102 PM ANNE STELLA 09 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BEL AIR, MARY LAND

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, BRIGHTVIEW ASSISTED LIVING HARFORD 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year 20 PENNSYLVANIA 1 □ M 2 🗗 F 173-12-3960 Director 01-08 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 23a or 28a-f show HARFORD MD BEL AIR 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA KING FACTORY 21014 300 WEST Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Evanition in 11. Marital Status 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 ò If Yes, Give Year or Dates Specify WHITE 2 Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) own home 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McCAIN WESTCOTT WESTCOTT RAYMOND ည VESTA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau PARKTON, MD, 21120 HILLSIDE VIEW RD. SARA YOSUA /dauanter 1003 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-20-09 BALTIMORE, NATOMY BOARD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROTT 1 S Ward <sup>22</sup> Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) **Physician** . 0 . . mouth /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause in the cause of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Physician/Medical attending p ası IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed' certificate 2 No 2 **N**O 1 TYes 1 □Yes Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Qther (Specify) LIVING Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at or Attending 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: сотріете ў filled in by the ☐Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 29a. Certifier 🛸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

D

DAVID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAVID S. DUNN, M.D. HARFORD P HARFORD PRIMARY 32 Règistrar's Signature

615 W. MACPHAIL ROAD BELAIR, MD 21014 SUITE 106

29d. Date signed (Month, Day, Year)

10-13-2009

Box 68760,

P.0.

Division of Vital

29c. License number

amend #19a Per Fil C896 10/20/09 JH Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Delma V. Fisher 1:15 Дм 13,2009 October /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Forest Hill 1618 Morse Road 8. Date of Birth (Month, Day, Year)

April 28,1918

9. Birthplace (State or For Country)
Pennsylvania Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🔀 F Yrs. 218-01-1345 91 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 XNo Middle River Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21220 Funeral 10 Armor Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify white ģ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 h (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Airflight Refueling Machinist marked other traumatic event, and 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill the sith and Mental Hitem 27 is marked ott Be Mary Eleanore Sanders Lloyd Sites ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
417 Kennard Avenue-Edgewood, Maryland 21040 19a. Informant's Name/Relationship (Type. Paraghter Juanita Coleman-<del>spoĭ</del> Itimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages permit. Pages Department of Important: If It any injury or o once. to 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.20,2009 Baltimore, Maryland Oaklawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 KME andree 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCED /Medical Due to (or as a consequence of): Examiner ONONN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and assets. iner Due to (or as a consequence of): burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) □Yes 2 No the detached 9 Unknown 9 Unknown Š signed by the period of the pe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 ☐ Probably 4 ☐ Unknown 2 / No 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate ! 2 🗆 No 1 ☐Yes 2 No 1 Yes ospital or Attending Physician: The hours after death.
uneral Director: After this certificate ity filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 2 11No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier (2.0 DOD17148 me to Me 10-14-09 21214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARTOND ND, J:2, 6 4706 DONATO A. VARGOSS, 7.0 32. Registrar's Signature 31. Date filed (Month. Day. Year) State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar amend 24–29 per Dr. g896 Contificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9:00PM ANIRAH SHANI FIETCHER 2009 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE CHEORGES Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year 1 □ M 2 🖾 F Sept 20, infant Director 2009 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 28a-f show other traumatic event, the Medical Eventings must be notified at 1 □Yes 2√ No Director Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3917 Essence Court 20748 "natural", or items 23a b1ack Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than" Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Pages 1 and 2 should be ပ Janay Fletcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Southern Maryland Hospital 7503 Surratts Road Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NQther (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EVEVR /Medical Due to (or as a consequence of): Examiner Dre mat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-trans and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy ō Vear Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o the detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has was autopsy performed? certificate 1 ☐ Yes 2 ☐ No Vital 1 □Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∰No 1 Thpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA o this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital within 24 hours a 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

...............................

b

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURRATISRD CLINTON MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G896, 10/19709, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 8, 2009 11:55 P M Nancy Frederick 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month. Day 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🕅 F 286-30-3211 Yrs. 79 09/25/1930 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1XYes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 299 Hurley Avenue 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2K No Specify 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Artist Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Ayres Marjorie (Unavailable) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Frederick Cada/Daughter 26 Almaden Place, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State October 14, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Bethesda-Chevy Chase A. Inc. 7557 Wisconsin Avenue 21. Signature of Funeral Service License M01498 Bethesda-Chevy Chase Inc. Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Pneumonia 3 weeks disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 1☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 □Yes 2 □ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

/Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-tran

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examinating the notified at

er than "natural", o

with the I

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Thent of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23.

f Health and Mental I tem 27 is marked of other traumatic eve

Department of Health Important: If item 27 any Injury or other tr. once.

**Physician** 

attending physician and for use as the burial-tran

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one) 29b. Signature and

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahryar Davari, M.D. 10110 Molecular Drive Suite #2, Rockville, Maryland 20854

29d Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) OCT 16 2009 37. Registrar's Signature

1<mark>d Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

09-07924			pe or Print i							egible		
Angela Rebecca		cher Si 1- For State	tate of Maryla		rtment of l tificate of L		id Me	ental Hy	giene		211	19 9316
Physici		Registrar  1. Decedent's Name (First, Midd	lle Last)	Cert	ilicate of t	Jean 			2. Date of De	Reg. No.	Erme VIV	3. Time of Death
Physici Medical Exam			ebecca	Fischer	c				Month October		Year	
		4a. Facility Name (if not instituted 261 Gina Court	on, give street and n	umber)		City, Town, o	r Location	n of Death			County of nne Aru	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las		If Under 1 Ye	ar Iftin	nder 24Hrs.	8 Date of 8			Birthplace (State or
Director		215-02-0689	1 M 2 F	7. 7.go (III yre. la.		Months Da				5/19		Foreign Country) CA
		Usual Residence of Decedent	I IVI ZX F		3.4 Yrs.				03/3		, ,	,, CA
any		10a, State 10b, County		10c. City, 1	Fown or Location	1		.,.				10d. Inside City Limits
and show	ь	Maryland An	ne Arunde	1		P	asad	ena				1 Yes 2 No
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of Wha	at Country?
th the 23a or 10tifie		261 Gina Court					211					JSA
tems 2	Funeral	<ul><li>11. Marital Status</li><li>1 Never Married 2 x N</li></ul>		cedent Ever in U.S orces?		Decedent of H , specify Cuba				No-	14. Race - White,	American Indian, Black, etc.
ter des	F		1 Yes	2 ∑ No ear	1 1	es 2 N	o specii	fv:			Specify:	White
urs af tural'	d by	15. Decedent's Education (Spe	or Dates:		16a. Decedent's	Usual Occupa	ation (Giv	e kind of w	ork done			iness/Industry
72 ho 12 ho 11 "na	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	during mos	t of working life	e. DO NO	OT use retire	ed)			
OO3( within lene.	티	12	1			Homemal						sehold
15-( filed v of oth t, the		17. Father's Name (First, Middle					18.Moth	ner's Name	(First, Middle		Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	To Be	William  19a. Informant's Name/Relations	Grant ship (Type, Print )		19b. Mailing A	ddress (Stre	et and N	umber or R	Unkn ural Route N		y or Town	, State, Zip Code)
MD de 2 shoulth and an 27 is a numatic		John Paul Fisc		spouse)		ina Cou					-	
e, P. I and I and Healt		20a. Method of Disposition	. 🗆		lace of Dispositi		emetery,	Oct	Date		ocation - 0	City or Town, State
MO! Pages ent of ut: If		1 Burial 2 X Crematio 4 Donation 5 Other S		Toni State	ro Crem		Inc.		2009	- 1	timo	re, Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. S ature of Funeral Se vio	Lynsee		22. Na	me and Addres	s of Faci	ility	Stall			ral Home. P.A.
	- 3	Ly )	D) (	1								MD 21122
Physician /Medical		23a. Part I. Enter the disease, of failure. List only one cause	e on lac line. In	[luenza]	HlNl In:	fection	соп	mplica	respiratory a	arrest, shoo <b>y</b>	ck, or hear	Approximate Interval Between Onset and Death
xaminer	1	Immediate Cause (Fin I disease or condition resulting in eath)		nia, car		ly, abd	lobe	sity	<u> </u>			Deali
		Sequentially list conditions,	b	u concoquentos en,								
	ie.	if any, leading to immediate cause. Enter Underlying Cause		a consequence of)	):							
#	Examiner	(Disease or injury that initiated events resulting in death) Last	C	a consequence of)								
ecuted and transi	<u></u>		d									
ords, P.O. Box 68760, w requires that the death certificate be ex s been signed by the attending physician should be detached for use as the burial	edic	X UNPENDED	AMENDED		I,27,pe	rmE, g8	97 1	1/24/	'09_TT			
876 ificate ig phy	Ž	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregn- birth		death 3	Ecto	pic pregnar	ncv		. Date of d Month	delivery Day Year
x 61 th cert ttendir r use a	hysician/M	past 12 months?	4 Preg	nant at time of dea	46	(Specify)						
Bo ne dear the ar	ş	1 Yes 2 No 9 V Un	Ja Cilki						oo. Die	1		usta to the serves of depth?
P.O.	by P	Part II. Other significant condi Peripheral p	·		•	derlying cause	given in	Рап I.				Probably 4 Unknown
ds, l		refipheral p	ишопат у	птошьое	шротт				1 24a. Wa			/ere autopsy findings available
COTC law re has be	Completed								aut	opsy formed?	pr	ior to completion of cause of eath?
Re : The ficate		05.111				00.51			1 Yes	2 No	1 [	Yes 2 No
n of Vital Recoring Physician: The law rather this certificate has burneral director, page 2 sh	a	25. Was case referred to medica examiner?	I Inneital:	Inpatient 2 I	ER/Outpatient		Other	th (Check o	g Home 5	Resider	nce 6 🗸	Other: Scene
Of V g Phy fter th	은	1 ✓ Yes 2 No 27, Manner of Death			28b. Time of Inj		ury at Wo		28d. Describ			
OD reading sath.	흹		ding	n, Day, Year)		1	Yes 2	No				
Division of pital or Attending Phours after death.  eral Director: After if filled in by the funeral	ij		estigation 28e. Pla	ce of Injury - At ho	me, farm, street,	factory, office	building,	etc.	28f. Location or Town		nd Number	r or Rural Route Number, City
Points a	Certification:	4 Homicide	ermined (Specify,	)						, otato,		
To the Hobital or Attending Physician: The law requires that the death certificate be executed Point and after the Hobital or Attending Physician: The law requires that the death certificate be executed Point after death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		(Ontook only	Physician: To the be aminer:On the basis	-								
DY OF THE	Medical	29b. Signature and title of certifi	and manner			29c. Licen				_		d (Month, Day, Year)
		D_m)				0.0	.M.E.			Octo	ber 13,	2009
		30. Name and address of person	n who completed cau	use of death (Item 2	23a)							
		Donna M. Vincenti, M		Medical Exam		Penn Stree	t, Baltir	more, MI	D 21201			
	-	31. Date filed (Month, Day Year)	32 R	legistrar's Signatur	·A							

ORIGINAL

Registrar

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State o	f Maryland	Departmen	nt of Healt	h and Mei	ntal Hygiene	

		,	For State Registrar	State of Ma	ryiand	-	rtment of F tificate of i			giene Reg. No. 🦪 🗎	7 (7)	00100
	Physici	an	1. Decedent's Name (First, Middle, Richard	Last) Ellswort	h	C1	asgow.		2. Date of Dea	ith Day	Year	3. Time of Death
and .	/Medic	al	4a. Facility Name (If not institution,		11			Location of Death	October	13, 200		11:20 p.M
لمر	Examin	er	7400 Holly Avenu				Takoma			Montgo		7
	Funeral Director		231-64-3704	Sex 7. Age 1	(In yrs. lasi 2	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Oct. 26	, Year) , 1926	9. Birthp Cour I111	place (State or Foreign htry) nois
	yland		Usual Residence of Decedent  10a. State 10b. County	i i	10c. City, T						1	0d. Inside City Limits
	Ba-f sl	Director	MD Montgon	nery	Tako	ma Pa						1 X Yes 2 □ No
	with the		10e. Street and Number 7400 Holly Avenu	10			10f. Zip Code 20912			10g. Citizen of Wh United S		,
36	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar mast be recilled at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces?				lispanic Origin? (Sp an, Mexican, Puerto Specify:			- Americ White,	an Indian,
2-00	72 hou natura		15. Decedent's (Specify only highest of	Education	1	6a. Deced	lent's Usual Occup	ation	ina	16b. Kind of Bus	iness/ine	dustry
121	within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	C		ght Atto	during most of work i) rnev	ing	Library	of	Congress
d 2	al Hygid other	Be Co	17. Father's Name (First, Middle, La		10	оругт	gire neco		e (First, Middle,	Maiden Surname,		CONGLESS
ylan	should be fand Mental s marked o	To B	Mark Glasgow					Ida Rhir	ndfleisc	h		
, Mar	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship Kristen Gorman	(Type. Print) (daughter)	7	19b. Mailin <b>400</b> H	g Address (Street lolly Ave	and Number or Run Takoma	Park, M	er, City or Town, S aryland	tate, Zip 2091	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health e Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐ Removal from State		apeak	sition (Name of natory or other place te Cremat	ory 200			le,	Maryland
Balt	permit Depart Import any Inj once.		21. Signature of Fundin / Service Lic	3	M0098	2 93	3 Gist A	ve. Silve	r Sprin	g, Maryl		on Service 20910
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshook, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the control of the cause on each line a. Shy-Drag Due to (or as a	er Sy	ndron		ig, such as cardiac	or respiratory an	rest,	1	Approximate Interval Between Onset and Death
	pe iii	iner	Sequentially list conditions, if any, leading to immediate cause. Filler U. donying	b Due to (or as a	consequen	ce of):						
68760,	ifficate be executed g physician and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequen	ce of):						
	tifficate ng phy as the	ledical		d								
.O. Box	attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal de	ath 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont		ery Day Year
ords, P.	law requires that the das been signed by the 2 should be detached	by	Part II. Other significant conditions	contributing to death but	not resultin	g in the un	derlying cause give	en in Part I.				ne cause of death? pably 4,\(\sum_1\) Unknown
Division of Vital Records,	ician: The law re certificate has be ector, page 2 sho	Completed							24a. Was a autop: perfor 1 □ Yes	sy pri med? de	or to co	psy findings available mpletion of cause of 2 □No
<u> </u>	sicial s certification	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	0.750	(0. +	Othe	26. Place of Deat				
of C	ding Phys n. After this funeral dir	ü	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day,	28	b. Time of Injury	28c. Injur	4 LI Nursing Ho		ence 6 ☐Other ow injury occurred		<u> </u>
sior	Attending Physician: It death. ector: After this certific. by the funeral director,	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	on			M 1 🗆	Yes 2 □No				
Divi	tal or Attencts after death al Director:	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		/ - At home (Specify)	, farm, stre	et, factory, office		28f. Location <i>(S</i> City or Tow	treet and Number n, State)	or Rura	l Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of e and manner state	examination	dge, death and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and man date and place, ar	ner as s id due to	tated. the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier	ongo (	21/	de	29c. License D2935			29d. Date signed o		
			30. Name and address of person who George Graves, M	o completed cause of dea	th (Item 23	a) (Type, F	Print) e. Suite	1400 Che	vy Chase	e, MD 208	315	
	Sta Registra		31. Date filed (Month, Day, Year)	32 Registrari	Signature	,	Jak		,			
				pull	1	1	11					

		for State Registrar	State	of Maryland /		artment of F rtificate of		-	A	39	33161
		1. Decedent's Name (First, Midd	le, Last)					2. Date of Dea	ath		3. Time of Death
Physici		Phvllis Joan Ge	rechaneck	-				Month	Day 12, 20	Year ()(9)	11:46 AM
/Medic		4a. Facility Name (If not institution				4h. City Town, a	r Location of Death		4c. County		11 1011
Examin	er	Prince George's				Cheve			· ·		eorge's
		5. Social Security Number	6. Sex	7. Age (In yrs. last b	nirthdav)	If Under 1 Year	7	8 Date of Birt			place (State or Foreign
Funeral Director		055-20-0341	1 □ M 2 1 F		) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Nov • 15	Year) 1928	Coul	ntry)
		Usual Residence of Decedent		00				1100. 10	1 1020	_ILa.	T y
land		10a. State 10b. County		10c. City, Tox	wn or Lo	ecation				1	0d. Inside City Limits
Mary if sh	ò	M 3 3 5 5				N.C. 31					1 □ Yes 2 <b>X</b> No
the 28a	Je.	Maryland Princ	e George'	s ur	pper	Marlboro	)		10g. Citizen of W	/hat Cour	ntry?
with a or	ቯ		m				774		United	State	es
be filed within 72 hours after death with the Maryland utal Hygiene.  Hygiene.  Hydiene.	Funeral Director	10729 Castleton		cedent Ever in U.S.	12		)774	posify Vos or No.	of Amer		can Indian,
item	Ë	11. Marital Status	Armed F	forces?	13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	Rican, etc.)	Blac	k, White,	
s aff	by	1 ☐ Never Married XX Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2⁄Ω(Nο hive Dates:		1□Yes XXNo	Specify:		Specify	T.Tlo 2 .	L _
hour tural	D.				2 Daga	dont's Herrel Ossur	otion		10h Vind of Du	Whi	
"nat	Completed	(Specify only highe	nt's Education est grade completed	) 16	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worl	king	16b. Kind of Bu	SINESS/III	dustry
vithir ane. <b>than</b>	ᇤ	Elementary/Secondary (0-12)	College (	(1-4or 5+)	me.		•		0		•
filed within Hygiene.  other than "sent, It is the	ပိ	12th	/ cost)			Telebuor	ne Operat		Commun		lons
be fi tall H id of evel	Be	17. Father's Name (First, Middle,	Lasij				18. Mother's Nam	ie (Filst, Middle,	Maiden Surnam	<i>e)</i>	
2 should be f and Mental is marked o aumatic eve	မ	Joseph Baldi					Maria (	Ouintess	sensa		
2 sh and is m	8 3	19a. Informant's Name/Relations	ship (Type. Print)	19	b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)
교 는 C 후		Joseph J. Gersc	haneck (H	lusband) 10	729	Castleto	n Turn, l	Upper Ma	rlboro,	Mar	yland 2077
permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.	1 %	20a. Method of Disposition		20h Place	of Dispo	sition (Name of matory or other plac FOYEST	i	Date	20c. Location -	City or To	wn, State
Page nent int: Ir			3 □ Hemoval from Specify)			Forest Cemeterv	30	21,	rinaa M	11110	, Maryland
mit.		21. Stinature of Fundation	Licensee	Merer	22	2. Name and Addre	ss of Facility EC	khardt F	uneral	Chape	el, P.A.
permi Depar Impor any ir	. 10	(m) (m)	nih							_	and 21102
		23. Part 1 Enter the disease of	complications that	caused the death. Do						1	
		231. Part 1. Enter the disease, or shock, or heart failure. List Im diate Cause (Final	only one cause on								Approximate Interval Between Onset and Death
Physician		disease or condition resulting in death)	a	FATA	٧	Cons.	AC 1	Humm	MA		
/Medical Examiner		resulting in death)	Due to	(or as a consequence	e of):	CARI).					
	Ļ.	Sequentially list conditions,	b	111-771	30	Lic	A-C00	55			
sit ed	ine	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	P be to	(or as a consequence	ol).						
icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c								
e ex	<u> </u>	resulting in death) cast	Due to	(or as a consequence	e of):						
ficate be executed physician and sthe burial-transit	edical		d								
rtific ng p		IF FEMALE:	1								
ding Physician: The law requires that the death certific has a face that seemed by the attending process the confliction of the face of the confliction of the confli	Physician/M	23b. Was decedent pregnant		utcome of pregnancy birth 2  Fetal deal	th al	☐ Ectopic pregnanc	v			e of deliv	
dear de att	ic i	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pre	gnant at time of death		Other (specify)	·		Mo	nth	Day Year
t the by th ache	hys	9 🗆 Unknown	9 □ Unk	nown							
s tha	by P	Part II. Other significant conditi	ons contributing to	death but not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contr	ibute to t	he cause of death?
uire; n sig								1 □ Y	es 2 No	3□ Prol	pably 4 ☐ Unknown
v rec	Completed							24a, Was a	n 24h V	Mara auto	anay findings available
has je 2	m							autop	sy / p	rior to co leath?	psy findings available impletion of cause of
r. Th cate pag	ပိ							1 □ Yes	2 No 1	Yes	2 □ No
clan ertifi ector	Be	25. Was case referred to medica examiner?				I -	26. Place of Dea	th (Check only o	ne)		
hysic his c		1∐ Yes 2 No	Hospital:	Inpatient 2 ER/C	Outpatier	nt 3 ☐ DOA Oth	er: 4 ☐ Nursing H	ome 5 Resid	lence 6 🗆 Oth	er (Speci	fy)
ng P	ü	27. Manner of Death 1 ☑ Natural 5 ☑ Pendin	28a. Date (Moi	e of Injury 28b. nth, Day, Year)	Time of Injury	f 28c. Injur Worl	y at k?	28d. Describe h	ow injury occurr	ed	
ath. Pr: A	aţic	2 ☐ Accident investi	gation				Yes 2□No				
Atte	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Plac	e of Injury - At home, thing, etc. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numb	er or Run	al Route Number,
d in Dir	Certification: To	4 El Torrioldo	Duile	ang, etc. (opecny)				City of Tow	n, State)		
To the Hospital or Attending Physician. The law requires that the death certif within 24 hours affect et al.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical (	29a. Certifier 1 ☑ Certifyii (Check only one) 2 ☐ Medical	Examiner: On the	e best of my knowled basis of examination a nner stated.	ge, deat and/or in	h occurred at the til vestigation, in my o	me, date and place pinion, death occu	e, and due to the rred at the time,	cause(s) and ma date and place, a	nner as a	stated. o the cause(s)
o the	Me	29b. Signature and title of ce life				29c. Licens	e number		29d. Date signed	(Month.	Day, Year)
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							53703		1011	4/5	77
10		30. Name and address of person	who completed cau	of death (Item 23a)  O4 QUEENSE  Decistrate Signature	) (Type,	Print)	De Cara Anie	111 -	1770		
		1510N BERHANE 31. Date filed (Month, Day, Year)	M.D., 440	9 (XUSENS) Registrar's Signature	BWUY	KOHO, K	MERCHLB	, NO Z	0730		
Sta Registra			32.	logistrar's Signature	•	ø'					
	:1	007 4 0 200	1 4	v 10 16 1	A 100	COP .					

\$08IN M. HILL (MRN# 216842186)
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ian	1. Decedent's Name (First, Midd	dle, Last)						2. Date of Do Month	eath Day	Year	3. Time of Death
cal	Robin Hill							10	04	2009	14:51P
er	4a. Facility Name (If not institution	on, give stree	et and numbe	er)		4b. City, Town	, or Location of Dea	th	4c. Co	unty of Death	,
	Good Samarit  5. Social Security Number	an Hos		Age (In yrs. la:	et hirthday)		imore ar   If Under 24 Hr	S   0 Date of Pi	rth	O Dieth	nlone /Otate ex Fare
	216-84-2186 Usual Residence of Decedent	1 M		43	Yrs.	Months Day		. (Month, D	rtn ay, Year) LC/1960	Cou	place (State or Fore ntry) :yland
	10a. State 10b. County	у		10c. City,	Town or Lo	cation			-		10d. Inside City Lim
Director	MD			F	Baltim	nore					1x Yes 2□
Dire	10e. Street and Number					10f. Zip Code				of What Cou	ntry?
ral	1521 Madison						21217			SA	
by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Mai  3 □ Widowed 4 □ Divorced	rried 1	Vas Deceder Armed Forces I ∐Yes 2 ह f Yes, Give ⁄ear or Dates	No		Was Decedent o If Yes, specify Co 1 □ Yes 2🌠 N	f Hispanic Origin? ( uban, Mexican, Pue o <i>Specify:</i>	Specify Yes or Norto Rican, etc.)		Race - Americ Black, White, pecify: bla	etc.
Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)		n npleted) College (1-4o	r 5+)	16a. Deced (Give life. L	dent's Usual Occ kind of work don DO NOT use reti	cupation ne during most of wo red)	orking	16b. Kind	of Business/In	dustry
Š.	12		Oilege (1-40	( 5+)	nur	sing as	sistant		hea]	Lthcare	!
Be	17. Father's Name (First, Middle,							me (First, Middle			V 1
2	Frank Bailey .	Jr					Josep	hine Mal	one		
	19a. Informant's Name/Relations		Print)		19b. Mailin	ng Address (Stre	et and Number or F	ural Route Numb	er, City or To	own, State, Zip	Code)
	Kevin Hill/spo	ouse					n Avenue			21217	
	20a. Method of Disposition 1	Specify)		Wes	5 TERN	sition (Name of natory or other p	meter 10/1	Date 4/2007	BAITI	ion - City or To	NARYLAK
	21. Signature of Funeral Service Romand Dietrich N.	S Wad Willi	e, Din	rector erDVR	S 22 2 1	Name and Add	ress of Facility Jos tomy Boar ulton Aye	eph H. 1 d 6551Wi	Brown . Balti	MD <sup>r</sup> 212	neral Hor
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AMEND TILEM#21perFH, G895, 10/16/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Detober Year **Physician** 3:30 PM 2004 Hayneswort /Medical 4c. County of Peath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospital Secours If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Menth, Day Birthplace (State or Foreign 6. Sex 9. Funeral Hours 1 □ M 2 💢 F Months Days 4-50-957 outh GATOlin Director Usual Residence of Decedent 10b. County 10d. Inside City Limits show T is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Mudical Experiment must be notified at 1 Nes 2 No imore Director 10e. Street and Number 10f. Zip Code Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. 11. Marital Status 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event, the Magnesian Once. Elementary/Secondary (0-12) College (1-4or 5+) 18 other's Name (First, Middle, Maiden Surname) Name (First, Middle, Las Be NESWON erena ပ 19b Mailing Address (Street and Number of Rural Route Humber, City or Town, State, Zip Code) 19a. Informant's Nam Relationship 750 Sona DINd rece BAHAMI 2122 Place of Disposition (Name of American Company) \*Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 R 3 Removal from State Zion 21. Signatura of Funeral Service Roans 22. Name and Address of Facility ALL 23a. Part1. Enter the disease, or complications that cause I the de mishock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and De Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death Immediate Cause (Final Physician hypotasion disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hemation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) anoxic 5 calattending physician and for use as the burial-tran requires that the death certificate be exect Due to (or as a consequence of): udden Physician/Medical hours IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) P.0. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autop performe 2 of Vital 1 □ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes After this 1 patient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier < 66108 October 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore, MO 21223 Simmons 2000 Baltinore St. Date filed (Month, Day, Year) 32. Registrar's Signature State post Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10014-2009 Year Carroll L. Heim 0930 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number Sex 1X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Days Min. Months Hours 217-34-3257 0(Month 1 Day 1 937 Director 72 Yrs Usual Residence of Decedent or 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Edgewood 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral is marked other than "natural", or items 23a 2220 Rosewood Drive 21040 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. 3 X Widowed 4 Divorced White Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 4 College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Supervisor Office Designs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph C. Heim, Sr Clara E. Ruppel DETOBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Joseph C. Heim, Jr. (Brother) 9541 Longview Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Bel Air Memorial Gar. 10-16-2009 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, MD 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signat Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician LUNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 $\square$ Live Birth 2 $\square$ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Cther (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the 9 Unknown 9 Unknown P.O. sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Albert performe Director: After this certificate 2 🗌 No Yes 1 Tes of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 3. Time of Death **Physician** Month 4:15 AM 200 John Bernard Herold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SYSTEM Coc: PERRY Point If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 24 Maryland **Funeral** Months 566-34-8527 Director 85 February 15,1924 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov Director 1 □Yes 2 □ No Md. Cecil Perry Point 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23A Perry Point 21902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ĀYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify: White þ If Yes, Give Specify. 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Handyman Self Employed Maryland . Pages 1 and 2 should be filk timent of Health and Mental H tant; If item 27 is marked oth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Walter Herold Catherine Margaret Franz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Goldsmith Niece 121 Carolstowne Rd. Reisterstown, Md. 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department o Important; If any injury or ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 10-13-2009 4 ☐ Donation 5 ☐ Other (Specify) Balto. Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate with metastasis **Physician** uncerE resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him or liab cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a sonsequence off the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O, Box 68760 the attending physician Physician/Medical as the IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) within 2. 29c. License number Rennsylving 29d. Date signed (Month, Day, Year) MD 0726921 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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John

Herold

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32. Registrar's gnatu

Bullock, M.D., VA MARY land Health Care System, Perry Point, MD 21902

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 12 octuber 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/23/1955 7. Age (In yrs. last birthday) If Under 1 Year If Under Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Days Hours 220-64-8755 53 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s ----- any Injury or other traumatic event, the Martin any Injury or other traumatic event, the Martin any Injury or other traumatic event, the Martin any Injury or other traumatic event, the Martin any Injury or other traumatic event, the Martin any Injury or other traumatic event, the Martin any Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event, the Martin and Injury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f Zip-Code 10g. Citizen of What Country? 2616 E. Monument Street Apt. #1 Funeral 21205 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 🔀 No If Yes, Give Year or Dates: þ 1 Yes 2 No Black 3 ▼ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Caterer Restaurant 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Glover o 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laticia Hill/ Daughter 5318 Beaufort Avenue, Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 10/15/2009 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licen 22 Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or samplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Drain Maria disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cardinac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner es a ponter Habba ell Hospital or Attending Physiclan; The law requires that the death certificate be executed spiratur Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 ZUnknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b page 2 s autopsy performed? Yes 2 No 2 🗌 No 1 ☐ Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1XInpatient Other: 2 ER/Outpatient 3 DOA 4 
Nursing Home 2 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury ours after death. 1 🗌 Yes 2 🗀 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (check only 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the P and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 October 12,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ) unald 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alan Theodore Hahn October 2009 11:03 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 18, 1950 **Funeral** 9. Birthplace (State or Foreign Months Davs Hours 141-44-2303 New Jersey Yrs. **Director** 58 Usual Residence of Decedent 10a. State 10b. County Director 10c. City, Town or Location with the Maryland 10d. Inside City Limits notified 28a-f MD Baltimore Baltimore 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 9906 Britinay Lane 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 X Married 1 Yes 2)
If Yes, Give
Year or Dates. 2X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify. Completed 3 Divorced 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Health Care Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Donald Joseph Hahn Helen Marœv permit. Page 1 and 2 should be Department of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Hahn/ Wife 9906 Britinay Lane, Baltimore, MD 21234 If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or 10/19/09 Parkwood Cemetery Parkville, MD ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Harford Rd. Parkville, MD 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ase or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). the attending physician and shed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year n signed by the a ld be detached f 1 Yes 2 Unknown 2 No g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and tipe of ce 29c. License number 2009 who completed cause of death (Item 23a) (Type, Print) 30. Name and a VALLEY RD DULLNEY Registrar's Sig State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia		Registrar 1. Decedent's Name (First	, Middle,	Last)							2	Date of Dea	_	Year	- 0	3. Time of Deal	h 🗸 🗍
dical Exami		Adam M				n						October 1	14, 20	09 c. County of	Death	1540 hrs	
		4a. Facility Name (if not in 13217 Old Hanov			number)		4	b. City, To		cation of E	Death			s. County of Baltimore		ntv	
<b></b>	4	5. Social Security Number		. Sex	7. Age (In yr	rs, last bir	thday)	If Under		If Under 2	24Hrs.	8. Date of B		/D0/YYYY)	9. Birth	place (State or	
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	-	Usual Residence of Dece		1/1 AM 2 F		1.9	Yrs.					Jan.	0,	1990			
any	ŀ	10a. State 10b. C			10c. C	City, Town	or Location	on								10d. Inside City	
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faryla 28a-f	Director	10e. Street and Number						10f. Zip C	ode				10g. Ci	tizen of Wha	at Coun	try?	
the Manner		306 4th	Str	eet				1	733	1					S.A		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		A	ecedent Ever i Forces?	n U.S.		Oeceden				cify Yes or N	lo-	14. Race - White,		can Indian, Blac	ck,
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5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First,	Middle, L	ast)					18	3.Mother's	Name (	First, <b>M</b> iddle	, Maide				
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Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Signature Funeral	Service L	icensee												ape1 P	
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Division of Vital Records, P.O. Box Hospital or Attending Physician: The law requires that the death 24 hours after death. Funeral Director: After this certificate has been signed by the atteriety filled in by the funeral director, page 2 should be detached for ut	Certification:	3 ✓ Suicide 6 4 Homicide		not be mined (Spec	ify) At hom	ne						or Towr 13217 Old	n, State Hanov	er Pike, R	eisters	town, MD	
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the hin the uple	Medical	one) 2 Medi	cal Exar	niner:On the ba and mann	sis of examinat	tion and/o	or investiga	ition, in my	opinion	, death occ	curred a	t the time, da	ate and	place, and	due to ti	he cause(s)	
To wit	Me	29b. Signature and title of	4	r				290		e number				_		onth, Day, Year)	
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C C	Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed
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	For State	State of Mar		epartment of li Dertificate of			1	7 7				
	Registrar  1. Decedent's Name (First, Middle, Las.	t)		Jei lilicale di	Dealli	2. Date of De	Reg. No.	U	3. Time of Death			
sician	Carrietta Howa	,			Month	Day	Year 2009	11 0 5 pm				
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Director	10e. Street and Number		Dali	10f. Zip Code			10a Citizen	of What Cour				
Ö	4103 Rockfield	Avenue		<u>Lip</u> Codo	21215		USA					
Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of If Yes, specify Cub		pecify Yes or No		Race - Americ	can Indian.			
by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Rican, etc.)	Spe	Black, White, ecify: Bla	etc.			
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Be	17. Father's Name (First, Middle, Last) President Adger	name)										
2			04045									
	19a. Informant's Name/Relationship (7) Carrietta McKen	zie/Daugh	iter 41	lailing Address (Street 03 Rockf isposition (Name of crematory or other pla	ield Ave	enue Ba	altim	ore,M				
	20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	on - City or To Owne , I	wn, State Maryland									
	21. Signature of Funeral Service Livers	lee		22. Name and Address 5240 Rei					eralHome MD 21215			
	snock, or neart failure. List only of	23a. P. u.f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
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ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d.	Date of delive Month	ery Day Year			
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ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	At home, farm,	street, factory, office		28f. Location (S	street and Nu	ımber or Rura	l Route Number,			
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Ň	29b. Signature and title of certifier	Set 1	7.0.	29c. Licens	se number		29d. Date sig	gned (Month, I	Day, Year)			
	30. Name and address of person who co	mpleted cause of death M. D. 182. Registrar's	ı (Item 23a) (Ty	pe, Print)	tul of	- 3.1	+, MA	<i>(</i> (0)	•			
ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	ut 1705/	1 5001 01	ral	O MO	/ -				
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State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar Certificate of Death	, ,	J. No. 2009	33173		
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death		
/Medical	MARGARET ELAINE HUFFMAN	OCTOBER	13, 2009	7:31 A <sup>M</sup>		
Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death			
Funeral	331 Harwick Place, Apt. A1 Joppa  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Harford	place (State or Foreign		
Director	212-36-7870  Usual Residence of Decedent	8. Date of Birth (Month, Day, 12–1–1939	rear) Cour Mary	ntry)		
d 21215-0036  filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or items 23a or 28a-1 show ant, the Modicel Exantiner must be rotified at e Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits		
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fter d friter friter frun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married 2 Married  12  Married 1  Yes 2  No	Rican, etc.)	14. Race - Americ Black, White,			
Durs a purs a Fair, o	if Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	nite		
21215-0  ed within 72 hou lygiene. her than "natura it, the Madical E	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)	sina 16	b. Kind of Business/Inc	dustry		
within within than than than than than than than tha	Elementary/Secondary (0-12) College (1-4or 5+)					
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and and sum	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru.	ral Route Number, (	City or Town, State, Zip	Code)		
e, M 1 and 2 Health em 27 i	Michele L. Huffman / Daughter 313 Garnett Road, Jopp	<del></del>				
Pages Thent of I ant: If ite	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		c. Location - City or To			
Baltimol permit. Pages Department of Important: If is any injury or o	4 Donation 5 Other (Specify) Hilltop Service Corp. 10-1 21. Signaturer of Funeral Service Licensee 22. Name and Address of Facility		owson, Mary	land		
B Dep Dep Dep Dep Dep Dep Dep Dep Dep Dep	McComas Funeral Ho		Jon Mores			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	t,	Approximate		
Physician	Immediate Cause (Final disease or condition resulting in death)  a. (Therosciences) - 2 × fensi	Ve -	1	Interval Between Onset and Death		
/Medical Examiner	resulting in death)  Due to (or as a consequence of):					
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executed an and ial-transit	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated are or injury					
D, R	that initiated events resulting in death) Last c. Ny an Tena 1010.  Due/to/or as a consequence of):					
ox 68 /60, certificate be executed reding physician and use as the burial-transit //Medical Examir	d					
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death ce e attendi d for use	23b. Was decedent pregnant in the past 12 months?			23d. Date of delivery  Month Day Year		
P.O. BO) nat the death of by the attence letached for us.  Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Day Tou.		
ecords, P.O. law requires that the d as been signed by the 2 should be detached pleted by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?				
en sig		1 Yes 2 No 3 Probably 4 Unknow				
ecord law requir as been si 2 should B		24a. Was an	24b. Were auto	osy findings available		
al Record  The law requi cate has been s page 2 should  Completed		autopsy performe 1 □ Yes 2	d? death? INo 1 □ Yes	npletion of cause of 2 □ No		
VITAL ician: T certificat ector, pe	OXAMINET:	h (Check only one)	342			
Phys Phys ral dir To			ce 6 ☐ Other (Specify	)		
on ding th. After fune.	27. Manner of Death  1  Natural 5  Pending (Month, Day, Year)  28a. Date of Injury 28b. Time of Injury Work?  2  Accident investigation  28c. Injury at Work?  1  Yes 2  No	28d. Describe how	injury occurred			
VISION Attending or death. ector: Afte by the fune	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree	et and Number or Rura	l Route Number.		
LIVISION of tal or Attending F is after death.  al Director: After led in by the funers  Certification:	4 🗆 Homicide building, etc. (Specify)	City or Town, S	State)	10		
UNISION OF VITAL HER INC. To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.8 Medical Certification: To Be Comple	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	rad at the time date	and place, and due to	the equac(c)		
To the community of the the community of the the community of the the community of the the community of the the community of the the community of the the community of the commu	29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License nu	09 0	Date signed (Month, I	Day, Year)		
2	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Stephanie Linder MD 902 Averill Rd	Горра,	MD 210	85		
State Registrar	31. Date filed (Month, Day, Year)  32. Repistrar's Signature					
riegistiai	UCI I D 6007 Thomas B. Jacks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07930 State of Maryland / Department of Health and Mental Hygiene Anthony Holman Certificate of Death 1- For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 12, 2009 1435 hrs thone 10/ Medical Examiner ma 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Johns Hopkins Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Numbe 6 Sex **Funeral** Foreign Months Days Hours -1960 Country) Director 216-86-2623 1 1 M Usual Residence of Decedent 10d. Inside City Limits I0c. City, Town or Location 10b. County 10a State 1 Yes 2 No es 23a or 28a-f show e notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 Yes 2 No specify: Yes, Give Yaar Yes Divorce Widowed the Medic 1 Examiner ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) Baltimore, MD 21215-0036 onstruction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NAL Kicha event, t Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Bacto. madiera St, mother man 1112 20c. Location - City or Town, State 20b, Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) Cremation 3 Removal from State Burial remal Donation 5 Other Specify 22. Name and Address of Facility 21. Signature f Funeral Service Lioni the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure Mst only one cause on each line. Death M-dical Narcotic intoxication Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Penneral Director: After this certificate has been signed by the attending physician and 23a,27,28a-f,permE, g896 10/28/09 TT Physician/Medical X UNPENDED AMENDED ned by the attending physician detached for use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Month Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death icate has been signed by the attending page 2 should be detached for use as fi Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I Part II. Other significant conditions þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Be Other<sub>4</sub> examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 ဥ 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 1 Yes 2 X No lunk Natural Pending neral Director: A Fd 10/12/09 Fd 2:00 pm 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) / 01 Madeira St Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide found: residence determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 13, 2009 O.C.M.E

State Registrar

Assistant Medical Examiner 31. Date filed (Month, Day, Year 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month bei 130 ALICE ROSE JEWS LEE Q M /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Hospital Maryland General Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 ■ F Months Days Hours 218-18-018 Yrs Director JUNE 29, 1924 MARYLAND Usual Residence of Decedent 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Evariner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Directo MARYLAND BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 21230 OSTEND U.S.A. STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: þ 1 ☐ Yes 2 M No Specify Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROFESSIONAL YEARS BALTO. CITY PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD ည SEWS MILDRED CECILIA THOMAS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a CAROLYN M. GREER (DAUGHTER) 806 W. OSTEND ST., other t BALTIMORE, MID 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State <u>+</u> 5 1 ■ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. HILL CEMETER 10/15/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 'LDAR 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NJR, FUNCRAL HOME JUSEPH H. GROL 2140 N. FULTON AVE BALTIMORE, MD 2121. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of): Examine attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş s peen si should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a. Was an certificate has page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Yes 2 1 No 1 III Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 No the f 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Records,

the Maryland

Baltimore, Maryland 21215-0036

and 2 should be lealth and Mental

Pages 1

The law requires that the death certificate be executed Division of Vital

After this al or Attending P s after death. Il Director: After 1 within 24 hours a

State Registrar

filled in by

Medical

29b. Signature and title of certifier∧ adl

determined

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

70

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

4 ☐ Homicide

29a. Certifier

and manner stated

	•	For State Registrar	State of Maryland		triment of r tificate of			Reg. No.	HEC	Haranay .	
		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death	
hysici: /Medic		Joan Jeni	fer				Ochbe		2009	4:49 P	
xamin	_	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death		4c. Cou	nty of Death		
		Joseph Richey Ho			Baltim If Under 1 Year		Dots of Bir	th.	Q Birth	place (State or Fore	
ineral		5. Social Security Number 6. Sex	7. Age ( <i>In yrs.</i> i	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Cou	intry) ryland	
ector		213-32-4725 Usual Residence of Decedent	73				4/17/1	930	Mai	Lytalla	
A ti		10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Lin	
F Sh	ţo	MD	Ва					1 X Yes 2 ☐			
1 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?	
23a o 81 ba		4011 Colborne Roa	ad		21229			U.S.	Α		
ems ;	Funeral	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of I	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No Rican, etc.)		Race - Amer Black, White		
or it		1 ☐ Never Married 2 ☐ Married	1 ∐Yes 2 ⊠ No If Yes, Give		1 □Yes 2 🛣 No			Spe	ecity: B	lack	
Fral',	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:		1 11 11 10	-41		16b. Kind o			
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ther ant, II		17. Father's Name (First, Middle, Last)			J	18. Mother's Nam	ne (First, Middle	, Maiden Suri	name)		
marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Evantiner ruist by indiffied at	To Be	John M		Brow	m	Susie				Bruce	
7 is marke traumatic	F	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address (Stree	t and Number or Ru	ral Route Numb	er, City or To	wn, State, Z	(ip Code)	
27 is r traı	П	Qwendolyn Johnson/	Daughter-in-law	314	Crosby F	Road, Cato	onsville	e, MD 2	21228		
item 27 other tra		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other pla	ace)	Date	20c. Location	on - City or T	Town, State	
nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other (Specify)	emoval from State	atony Gi	ifts Regist	ry 10/1				aryland	
Important; If item 27 any injury or other tronce.		21. Signature of Funeral States Little 1		2:	2. Name and Addr	ess of Facility Ar	natomy (	Gifts F	Regist	ry	
E S		150501		1 7	7522 Conr	nelley Dr	., Ste.I	P, Hand	over,	MD 21076	
physician and the burial-transit	I Examiner										
ath certin attending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25000 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 death 5		and Did		23d. Date of delivery Month Day Yea			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26perPHYS, G896, 10716/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Day Year Physician Idhasun 6:30 AM 2009 Alverta 8 Oct /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Southridge 14 as ford Edgewood VK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 X F Yrs. 88 JAN 15 1921 MARYLAND Director 214-20-8012 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Itams 23a or 28a-f ahow other traumatic evant, the Medical Examinar must be notified at 1 Yes 2XXVo Director **EDGEWOOD** MARYLAND HARFORD CO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21040 1919 SOUTH RIDGE DR. death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes ŽOXNo Specify: Specify: BLACK 3₩idowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 is 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSEWIFE 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ဂ ADDIE OSBORNE HERMAN HOLMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 South Ridge Dr., Edgewood, Md., 21040 Althena L. Cornish/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of I Important: If It any Injury or o tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) COMMUNITY BAPTIST 10-17-09 JOPPA, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME -HARFORD, P.A 21. Signature of Funeral Service Licensee 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vears **Physician** ASCUD /Medical Due to (or as a consequence of) Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner as the burial-transit certificate be executed led by the attending physician and detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ menta 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Gangrene this certificate has autopsy performed? 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death Check only one Hospital: 1 Inpatient 4 Deugale Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) A Hospital or Attanding Pl 24 hours after death. Funeral Director: After the fulled in by the funera Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 BNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No М 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a
To the Funeral C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31295 Kley 30. Name and address of person who computed cause of death (Item 23a) (Type, Print)

Registrar

State

K10152

MD

31. Date filed (Mohin, Day Year)
OCT 16 2009

Kennood

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32. Registraris Signature

Bartonie md

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>Ο, **Physician** 2009 9:30 A M October Virginia J. Jones /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Northampton Manor Health Care Center Frederick Frederick 8. Date of Birth (Month, Day, You January 1, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** <sup>Year)</sup> 1923 1 □ M 2 🕅 F Months Days Hours Min. Washington, D.C. 86 Director 218-16-2187 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Frederick Director Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Evaniner must be none. 21702 United States 2100 Whittier Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pau1 F. Jefferson Unknown ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2425 Longfellow Court, Frederick, Maryland 21702 Rebecca S. Johnson /Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 14, 2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M01305 23a. Part 1. Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hoims Myo Condeal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and s the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Ye ar 5 ☐ Other (specify) been signed by the should be detached to 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has birector, page 2 sl autopsy performed? Yes 2/2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Stat

State Registrar 31. Date filed (Month

TOLL

801

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Card)

MO

16-12-09

House Ave Frederick, MD 21701

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Division of Vital Records, P.O. Box 6876 within 124 hours after death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	29a. Certifier 1 Certifying P (Check only 1 Medical Exa	hysician: To the b miner:On the bas	is of exami	knowledge, o nation and/o	death occu or investiga	rred at the ition, in my	time, da opinion,	te and place death occ	ce, and curred a	due to the o t the time, d	ause(s ate and	i) and mann d place, and	er as st I due to	ated. the cause(s)	
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3 3		30. Name a daddress if person	Moll, M	ause of dea	ath (Item 23a			_						-		
DYCO		Pamela E. Sputhall, N	MD Assistar	nt Medic	al Examir	ner 11	11 Penn	Street	, Baltim	ore, N	/ID 21201					
		31. Date filed (Month, Day Year)	32	datrar's	Signature						_					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dori Marie Lewis October 14. 2.009 8:35 P. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ KF Months Days Hours Min. Country) 220-80-3597 50 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f sho 10a, State 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director N/ABaltimore Maryland 1 
¥ Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3350 Chestnut Avenue 21211 America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ white If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify: "natural", 3 Divorced 4 Divorced Completed Baltimore, Maryland 21215-00 the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve and Mental Frederick Carl Chilcote Gertrude Estelle White 19a. Informant's Name/Relationship (Type, Print) SPOUSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ronald Scott Lewis, Sr./ 3350 Chestnut Avenue Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Fineral Service Licensee 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has blirector, page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28b. 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place in by the funeral completed filled fill Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State Registrar MI)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 11:55 AM LaPointe Duane Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Aug. 25 1930 Months Hours Min. Director 79 MI 212-28-2661 Usual Residence of Decedent 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 163 Mountain Road 21122 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 x No Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Connector 8 Iron Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Theodore LaPointe Jeanette Mooney other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Rompf (daughter) 1757 Westridge Drive, Hurst, TX 76054 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Important: If any injury or ò 1 Burial 2 X Cremation 3 Removal from State Oct. 15 Metro Crematory Inc. 4 Donation 5 Other (Specify) 2009 Baltimore, Maryland 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. r the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final aretion Cardia Physician/ disease or condition Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death detached g Unknown P.O. ģ signed t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 ┗No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes been si should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed' death? After this certificate funeral director, pag 2 10 1 🗌 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 🗌 Yes 2 A N Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work death. Accident Investigation M 1 Yes 2 No within 24 hours after death

To the Funeral Director. / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 009 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) mo 32. Registrar's Signature 31. Date filed (Month, Day, State OCT 16 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc 8897 11-4-09 vt
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	,	Ce	rtificate of	Death		Reg. No.	9 33183	
	Physici		1. Decedent's Name (First, Middle, Las	.t)				2. Date of Dea		3. Time of Death	
	/Medic		Wuantia C. Luch	y Wuanit	a G. Lus	by			ober 15,	2009 10:00 MM	
3x	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ath	4c. County of	Death	
1			Future Care Loc				Baltin				
10	Funeral		Social Security Number     6. Se	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h y, Year) 9	Birthplace (State or Foreign Country)	
	Director		218-30-5257 Usual Residence of Decedent		89 Yrs.			Sep 08	1920	Maryland	
	fand ow tt		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits	
	Maryl f sho ed a	6	MD Baltir		211					1 □Yes 2 No	
	the l	Director	MD Baltir  10e. Street and Number	nore	Pikesv	10f. Zip Code			10g. Citizen of Wha	at Country?	
	with 3a or t be						0				
	ns 2;	Funeral	7424 Rockridge I	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of H	lispanic Origin?	Specify Yes or No-	14. Race -	States American Indian,	
(0	of iter	큔	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ANo		If Yes, specify Cub		erto Rican, etc.)	Black,	White, etc.	
03	al", c	þ	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 SANo	Specify:		Specify:	White	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	oation	orkina	16b. Kind of Busin	ness/Industry	
2121	within iene. than "	힐	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	orking			
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Pu	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)					,	Maiden Surname)		
yla	12 should be filed w and Mental Hygie is marked other ti raumatic event, th	۵	Roth Albert Cast					ha Sterli			
Maryland	12 sh nand ris m		19a. Informant's Name/Relationship (7			•			er, City or Town, St	, ,	
	s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Carol Cassell /I		70 20b. Place of Dispo		d Mill R	oad Pikes	sville, M.		
Baltimore,	Pages nent of Hant of Hant: If ite		Burial 2 Cremation 3 🗆	Removal from State	cemetery, cre	matory or other pla	ce)	Oct 19,	20c. Location - Oi	ly or rown, State	
ţi	t. Partmer	-	4 □ Donation 5 □ Other (Specify			Memorial		2009	Sykesv	ille, Maryland	
Ba	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licen	see M0144	3   '	<ol><li>Name and Address</li><li>Crematic</li></ol>		neral Alte	ernatives		
			23a. Part1. Enter the disease, or comp	plications that caused the	death Do not en					ryland 21286	
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each line:	- 0	; X/-	1		Tool,	Interval Between Onset and Death	
Time.	Physician 'Medical		disease or condition resulting in death)	a. There	isclesot.	TCL//EA	11 175	ense		23m/S	
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	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	exec an an rial-tr	Exa	resulting in death) Last	C Due to (or as a co	nsequence of):						
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99	rtifica ng ph as th	Med	IS SELLIN S								
Box	eath cer attendir for use		Zob. Was decedent pregnant	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐		∃Ectopic pregnanc	v		23d. Date	· ·	
	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time		Other (specify)			Month	n Day Year	
P.0	ires that the de signed by the a be detached	Physician/	9 Unknown					The second			
	es th igned	by	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the u	ınderlying cause giv	en in Part I.			ute to the cause of death?	
orc	w requir been si should I	ted						.   10\	res 2 Laura 3	☐ Probably 4 ☐ Unknown	
or Vital Records,	e law has b	Completed						24a. Was	an 24b. We	ere autopsy findings available or to completion of cause of ath?	
E H		္ပြ						perfo 1⊟ Yes	rmed? dea	ath? ]Yes 2□ No	
/ita	ician; Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11		10.		eath (Check only o	ne)		
or	S S	<u>٩</u>	T Tes Zinko		2 ER/Outpatie		4 La Nursing		dence 6 □Other		
N N	ding Phy h. After thi funeral	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Wo		28d. Describe h	now injury occurred		
Sic	Attending r death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be		At home form et		Yes 2 No	20f Location /6	Street and Number	or Rural Route Number,	
Division	i gig a	Certification:	4 ☐ Homicide determined	building, etc. (S	pecify)	reer, ractory, office		City or Tow		or nural noute Number,	
_	purs a		29a. Certifier 1 Certifying Phy	ysician: To the best of m	y knowledge, deat	th occurred at the ti	me, date and ola	ce, and due to the	cause(s) and manr	ner as stated.	
	To the Hos within 24 hd To the Fun completely	edical	(Check only 2 ☐ Medical Exam	iner: On the basis of exa and manner stated.	amination and/or in	nvestigation, in my	opinion, death oc	curred at the time,	date and place, an	d due to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	land Ildan	`	29c. Licens			29d. Date signed	Month, Day, Year)	
			+ TXISE JUST	enop MI	,	D00	433 FX	<b>o</b>	10/15/0	7	
			1/.	completed cause of death	(Item 23a) (Type,				21136		
	1				MAZN ST	KEE 11	EISTENS	ICEDN, MIT	21136	>	
- A	Sta Registr	_	31. Date filed (Month, Day, Year)  OCT 1	32. Registrar's	Signature	1. Sans	1				

1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Year Day Month 11.25-AM **Physician** Lee Hannah 2009 October /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 12/2/1931 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Davs Hours 1 □ M 2KCXF 77 Washington, D.C 579-42-3650 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~- any injury or other traumatic events. 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Laurel 1 X Yes 2 □ No Prince George's Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 20707 5810 Parkway Drive by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Survey Statistician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Blagrove Watson Frances Louise Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5810 Parkway Drive Laurel, Maryland Kathryn L. Jones-Ewing (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cemetery 10/16/2009 Suitland, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home, Inc. 20011 4217 9th Street, N.W. Washington, D.C. 23a. Port.1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ract Urmary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Hemorehaue 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2▼No 24a. Was an page 2 s autopsy perform certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4K Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide within 24 hours a

To the Funeral [ 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 12,2009 DOUS3337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Secry Reaterstown Sute 200 25 Main am 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

09-07861 М

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aceo Ligon			nent of Health and Mental Hy cate of Death	giene Reg. N	VO.	3318
Physici ledical Exam	ian/	Name (First, Middle,Last) Maceo Ligon		2. Date of Death Month Da October 10, 2	3. Time of	
ledical Exam	iner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		St. Agnes Hospital	Baltimore			
Funeral Director		5. Social Security Number 212-46-6999 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	<b>⊣</b>	MM/DD/YYYY) 9. Birthplace (St. Foreign Mar Country)	yland
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	10d. Insid	de City Limits		
<b>*</b>	_	Maryland N/A	Baltimore		ĭXYe	es 2 No
Aaryland 28a-f show 1 at once	ecto	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
th the Maryland 23a or 28a-f sho notified at once.	D.	628 Queensgate Road	21229		USA	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27s marked other than "natural", or items 23a or 28a-f she fraumatic event, the Medical Examiner must be notified at once	Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian White, etc. Black Specify:	, віаск,
hours afte "natural", Examine	l by	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a	a. Decedent's Usual Occupation (Give kind of w	vork done 16	6b. Kind of Business/Industry	
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	ld m	12 cm grade	anufacturing Techr		Tedco Indus	tries
15-0 filed v I Hygi d other;	ပ္ပို	17. Father's Name (First, Middle, Last)	18.Mother's Name Eliza V	(First, Middle, Maid	den Surname)	
212' Ild be Mental	To Be	Maceo Trigon Sr 19a. Informant's Name Felationship (Type, Print)	19b. Mailing Address (Street and Number or F		r, City or Town, State, Zip Code	e)
MD 2 shot alth and 2 is 1 arm 27 is 1 arm arm arm arm arm arm arm arm arm arm	-		628 Queensgate Roa	ad Balti	imore,MD 212:	29
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other it mijury or other traumantic event, the Med			e of Disposition (Name of cemetery, natory or other place)	Date 2	Oc. Location - City or Town, Sta	ite
MOI Pages nent of ant: I			utus MemorialPark	// 10/01A	Arbutus, Mary	land
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ch	natman-E	Harris Funera	al Hom
		232 Part I. Enter the disease, or complications that caused the death. Do	15240 Reisterstow	ın Rd Ba	altimore.MD 3	21215 imate Interval
Physiciar /Medica		failure. Light only one cause on each line.			Betwee	en Onset and Death
xamine		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive at 1  Due to (or as a consequence of):	herosclerotic cardiov	ascular c	iisease	
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	xam	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
recuted n and ransit	a E	d. 232 27 pe	rmE, g897 11/3/09 TT			
), be es siciar urial	ğ	X unpended Amended 23a,2/,pe			23d. Date of delivery	
ision of Vital Records, P.O. Box 6876( Attending Physician: The law requires that the death certificate releath. extern: After this certificate has been signed by the attending physerion: he fineral director page 2 should be detached for use as the by	N/u	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth	cy 2 Fetal death 3 Ectopic pregna	ancy	Month Day	Year
Box 6876 e death certificat the attending phy ed for use as the	icia	past 12 months?  4 Pregnant at time of death 1 Yes 2 No 9 Unknown a Hoknown	5 Other (Specify)			
BO; he deat the at the at	12	o Dikiowii	ting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause	e of death?
P.O.	5	Part II. Other significant commons Continuous to death but not resur	ang in the angerying coose given in tarti		2 No 3 Probably 4	
ds, P equires t een sign	Completed			24a. Was an		
COF law r has b	l g			autopsy	ed? death?	
tal Re(ian: The certificate	3	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2 only one)	No 1 ✓ Yes	2 No
Vital hysician:	o Be	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER	Othor		esidence 6 Other:	
n of \ding Ph;  After tl funeral	-	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28	b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
ion tendii eath. Tor: A	턇	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rural Route te)	: Number, City
<u></u>	Š	4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge.				
	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, one) Medical Examiner: On the basis of examination and/o	death occurred at the time, date and place, and or investigation, in my opinion, death occurred	at the time, date an	nd place, and due to the cause(	s)
To the within To the complete	Med	29b. Signature and title certifier	29c. License number		29d. Date signed (Month, Day,	
	1	6 John Glade	O.C.M.E.		October 11, 2009	
		30. Name and address of person who completed cause of death (Item 23.	a)			
	1	Victor Weedn MD JD Assistant Medical Examiner		21201		
	State	0.077 4 0.0000 4	lan Ked			
Regi		1. 1	7			
DHMH 17 Rev 1	/2001	OCME	ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No.		
* Dhysisis		1. Decedent's Name (First, Middle, Lest)	2. Dete of I	Dav	3. Time of Death	
Physiciai /Medica		Donald M Lewis	Octobe		2009 6:00 A	
Examine			wn, or Location of De			
		Cullege Manor Luthe 5 Social Security Number 6 Sex 7 Ang (In urs last highday) If Under 1 Year   If Under 1			MUTE CHANGE	
Funeral Director		5. Social Security Number 219-10-4722  6. Sex 1	Min. 8. Date of I (Month, 1)	0, 1925	9. Birthplace <i>(State or Foreig</i> Country) Maryland	
p >		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits	
anyla show	2	MD Harford Bel Air			1 □ Yes 2 ☑ No	
the N	ect	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Country?	
ath with the Marylar 23a or 28e-f show ust be notified at	Funeral Director	1300 Fordham Court 21014		U	.S.A.	
or's e	2	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Original Hisp	gin? (Specify Yes or , Puerto Rican, etc.)	Black	o-American Indian, c, White, etc. White	
"neturel".	g	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	t of working	16b. Kind of Bu	siness/Industry	
nd 2 should be filed within 1 alth and Mental Hygiene 27 Is marked other than "r r traumatic event, the Med	Completed	Elementary/Secondary (0-12)  College (1-4or 5+) 2  College (1-4or 5+) Truant Officer	o. tronking	Baltimore City		
Hyg other ont,	Be C	17. Fether's Name (First, Middle, Lest)  18. Mother	er's Name (First, Midd			
lenta ked o	10 8	Arthur M. Lewis A	lda E	. Har	riel	
shound N		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	er or Rural Route Nur	nber, City or Town,	State, Zip Code)	
1 and 2 Health a em 27 is		Neil D. Lewis-brother 1300 Fordham Ct.,	Bel Air,	MD 21014		
of Healt Item 2: other		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location -	City or Town, State	
Page nent c nrt: if rry or		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) □ Dulaney Valley	10/17/	09 Timon	ium, MD	
permit. Pages 1 and Department of Healt Important: if Item 2 any injury or other once.		21. Signature of Funeral Service Licen William G. Dau  22. Name end Address of Facilit 1050 York Rd.,			1 Home, Inc.	
	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiac or respiretor	y arrest,	Approximate Interval Between	
Physician		snock, or neer failure. List only one cause on each line.			Onset and Death	
/Medical		Immediate Cause (Final disease or condition a Cerebrovascular Acadeses or condition a Cerebrovascular Acadeses of the condition of the conditi	cident		5 days	
Examiner		resulting in death)  Due to (or es a consequence of):			5 days	
P #	iner	_ Atherosclerosis			10 year	
cete be executed physician end sthe bunel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1.00			
The law requires that the death certificete be executed the bes been signed by the ettending physician end page 2 should be detached for use as the buniel-transi	Medical	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as e consequence of):	- 14 99-			
eath cert ettending I for use		d				
death	<u> </u>	Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I	. 23b. D	id tobecco use cor	tribute to the cause of deat	
hat the de ad by the detached	by Physician/	Hypertension		□ Yes 2 No	3 ☐ Probably 4 ☐ Unkno	
es tha igned be de	2	(19)001011		***	All Marian Cardina	
v require been si should	Completed		24a. W	as en autopsy arformed?	24b. Were eutopsy finding- available prior to completion of cause	
law r	ᇍ				of death?	
The law sete hes page 2	5		11	☐ Yes 2☐Mo	1 ☐ Yes 2 ☐ No	
ysician: The	9	ovaminor?	of Death (Check on	/	1	
Physic this ce	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nu	ursing Home 5□ R		er (Specify) 155051cd Li	
Jing Ph h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 4 Work?		oe how injury occurr	ed	
i or Attending Physician: after death.  Director: After this certificd d in by the funeral director,	Medical Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, offica	28f. Locatio	n (Street and Numb Town, State)	er or Rural Route Number,	
5 분 등 드	Ser	4 ☐ Homicide determined building, efc. (Specify)	Only of			
To the Hospital within 24 hours a To the Funeral completely filled	dical	29a. Certifier  (Check only one)  1	d place, end due to t th occurred at the tin	he cause(s) end me ne, date and place, a	nner as stated. and due to the cause(s)	
To the Hos within 24 hr To the Fun completely	Me	29b. Signeture end title of certifier  29c. License number	// //	29d. Date signed	(Month, Day, Yeer)	
	-	1 140	74	1001	1000/	
		30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)  Alexander W. Chen, MD Box	19099	Towson,	40 21284	
State		31. Date filed (Month, Dey, Year)  32. Registrer's Signeture	/	*		
Registra						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month /O **Physician** BARBARA 0620 M MADKINS (3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 313 Mary Lou Avenue Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗷 F Director 212-07-7597 93 02/20/1916 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Marical Experiment was be notified at once. Glen Burnie 1 ☐XYes 2 ☐ No MD Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Mary Lou Avenue 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2**X**]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕱 No Specify 2 3

Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Kraft Grace Sipe ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Hilton/Daughter 313 Mary Lou Ave, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 10/15/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licenses Laura C. Hardesty 7522 Connelley Drive, Ste.N, Hanover, MD 21076 M01197 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ¿ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Year 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2. No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Tyes 2 □No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Name and address of person



W

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 0+h MeCon 0156 AM 2009 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Cit Harbor Hospita If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Director 215-30-4888 3/27/1926 Virginia 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 U.S.A. 8008 Del Haven Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2X No Completed by Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 Is marked oth jury or other traumatic even Be Breeden Wright Ethel ပ Charles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1958 Ewald Avenue, Baltimore, MD 21222 Donna Lee Taylor/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If i any injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/2009 Anatomy Gifts Registry Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Severe Anemia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Bleedino Gastrointestinal Unthowy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown 1 Tes Dementia Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 400 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. Records, P.O. Division of Vital

within 24 hours after deat To the Funeral Director: completely

> State Registrar

(Check only one)

29b. Signature ap title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Scheraga D.O. 3001 South Hanover St. 31. Date filed (Month, Day

32. Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

40006 49

Baltimore, MD 21225

29d. Date signed (Month, Day, Year)

10/13/2009

09-07988 Jerome Maple Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rome Maple		St For State	ate of Maryla	and / Depa	rtment of l		and	Menta	l Hygi		g. No	20	9 3518
Physician edical Examine	/ 1.	Decedent's Name (First, Midd Jerome	e,Last)	Ma	ple				1 -	Date of Death Month October 14	Day Ye 1, 2009		3. Time of Death 1300 hrs
7		a. Facility Name (if not institution 18701 Roxbury Road	n, give street and nu			. City, Tow Hagerst		cation of [			4c. County Washin	gton	
Funeral Director	5	Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months		If Under 2 Hours		3. Date of Birl		Y) 9. Bir Co	thplace (State or Foreign untry)
ow any	1	Isual Residence of Decedent  Oa. State 10b. County  MD N	IA		10c. City, Town or Location Baltimore								10d. Inside City Limits  1 X Yes 2 No
ne Maryland or 28a-f show filed at once.	olication 1	Oe. Street and Number 2101 Whitt		nue		10f. Zip Co				1		zen of What Country?  USA	
\ \\ \(\pi\) = \  \ \frac{\pi}{2} \ \frac{\pi}	-uneral	Marital Status     Never Married 2 N	cedent Ever in U Forces? X 2 No	edent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specifices? V. No. 13. Was Decedent of Hispanic Origin? (Specifices? V. No. 13. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. No. 14. Was Decedent of Hispanic Origin? (Specifices? V. Was Decedent of Hispanic Origin? (Specifices) (Specifices? V. Was Decedent of Hispanic Origin? (Specifices) (Specifices? V. Was Decedent of Hispanic Origin? (Specifices) (Specifices? V. Was Decedent of Hispanic Origin? (Specifices) (Specifice					ify Yes or No can, etc.)	ify Yes or No- can, etc.)  14. Race - American Indian, Blac White, etc.  Specify:			
2 hours after "." "natural";	ਠ⊢	15. Decedent's Education (Sp Elementary/Secondary (0-12	) College		16a. Decedent during mo	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					ı		
215-0036 be filed within 7 ntal Hygiene. ked other than ent, the Medica	~ 1	11th Grade  17. Father's Name (First, Middle			Labo						Maiden Surnan	ne)	
D 2121 should be find Mental I is marked atic event,	To Be	Jerome  19a. Informant's Name/Relation	ship (Type, Print)	Maple,	Sr. 19b. Mailing 210	Address	(Street	Eli and Numb ier	<u>zabe</u> oeror <sub>(Ru</sub> Avei	eth ral Route Nu nue B	Wa mber, City or To altimo	tki own, Stat ore,	ns le, Zip Code) MD 21217
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical	1	Tyrone Map 20a. Method of Disposition  1 X Burial 2 Crematic 4 Donation 5 Other	on 3 Removal	from State 20b.	Place of Dispos crematory or oth ing Mer	ition (Name	of cem	etery,		Date 16-09	20c. Locatio	n - City o	stown, State
Baltimore, permit. Pages 1 ar Department of Hee, Important: If the		21. Signature of Funeral Servi	licensee		638	Name and A	Gi:	lmor	St	reet	Baltim	nore	me P.A. , MD 21217
Physician 'Medical aminer	4	23a. Part I. Enter the disease, failure. List only one caus Immediate Cause (Final diseasor condition resulting in death)	se on each line. se a. <b>Hero</b>		oxicatio		dyllig, s	SUCIT do Co	ardiac or i	oopii atory a			Between Onset and Death
	.	Sequentially list conditions, if any, leading to immediate	b Due to (or as	s a consequence									
xecuted n and - transit	Exam	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	Due to for pr	s a consequence	of):				_				
50, te be execu nysician and e burial - tra	Medical	X UNPENDED	AMENDE	23a,27,2	28a-f pe	er ME	g89	7 11	/09/	<u>)9 TT</u>	23d. Date	e of deliv	
Box 68760, e death certificate be the attending physic ed for use as the bur		23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 l	1 Live	e birth egnant at time of o known	2 F	etal death other (Spec	3 [ ify) _	Ectopic	c pregnar		Monti		Day Year
ires that the d signed by the dibe detached	≦	Part II. Other significant con	ditions contributing	g to death but not	t resulting in the	underlying	cause g	iven in Pa	art I.		es 2 No	3P	to the cause of death?  robably 4 Unknown
rds v requ	Completed									per 1 ✔ Yes	s an 24 opsy formed?		
Vital Rec ysician: The his certificate director, page	To Be C	25. Was case referred to med examiner?  1 ✓ Yes 2 No	ical Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 D	OA	of Death Other:	Nursin	g Home 5	Residence		ther: Scene
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2		27, Manner of Death 1 Natural 5 P	ending Fd	ate of Injury onth, Day,Year) 10/14/09		00 pm	1	ry at Worl	No	unk	e how injury od		Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification	3 Suicide 6 X C	ould not be etermined (Spec	,	1 ce11					Rd. H	agersto	wn,	MD
o the Hos ithin 24 h o the Fur	Medical	29a. Certifier 1 Certifying Check only 2 Medical I	Physician: To the examiner:On the ba	sis of examination	edge, death occ n and/or investig	ation, in my	opinio.	n, death o	ccurred a	at the time, da	ate and place, a	na aue i	o the cause(s) (Month, Day, Year)
	Me	29b. Signature and title of cer	Drothall	MI)		290		M.E.	r 		Octobe		
		30. Name and address of per Pamela E. Southall		cause of death (It int Medical E		11 Penr	Stree	et, Baltir	more, N	MD 21201			
St	ate	31. Date filed (Month, Day, Ye	ar)	. Registrar's Sigr	nature	12.3							

09-07944 Martin Mannion

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 13, 2009 Martin Joseph Mannion, 0451 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Mercy Hospital Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Director 10/04/1949 Country MD 1 M 2 F 218-52-0989 60 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No MD Baltimore Towson 28a-f show items 23a or 28a-f shorust be notified at once. hours after death with the Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 729 Camberry Cir. Apt. T-2 21286 USA 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status more, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with near of Health and Mental Hygiene.
ant: If it feet 27 is marked other than "natural", or items; an other traumatic event, the Medical Examiner must be a ror other traumatic event, the Medical Examiner must be a Armed Forces? 1 Never Married 2 2 X No Yes White 1 Yes 2 No specify: f Yes. Give Year Widowed 4 Divorced δ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) 12 College (1-4 or 5+) Livery Cab Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Draper Martin J. Mannion, Jr. Be 19b. Mailing Address (Street and Number or Rural Pouts Number City or Town, State, Zip Code)
14 Warren Lodge Ct. Cockeysville, MD 19a. Informant's Name/Relationship (Type, Print ) Madonna Garbe/Sister Date 16, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Oct. Chesapeake Crem. 2 > Burial Cremation 3 Beltsville, MD 2009 rtant: Donation 5 Other Specify 22. Name and Address of FathAra/Stephen D.Lohrmann P.A. Signature of Funeral Service Licensee M01442 8717 Green Pastures Dr. Balto. MD21286 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line Death a. Atherosclerotic Cardiovascular Disease aminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,

Physician /Medical

The law requires that the death certificate be executed and

Box 68760,

o

Records,

Division of Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director,

Examin	cause. Enter Underly (Disease or injury that events resulting in de
dical	UNPENDED
ian/Me	IF FEMALE: 23b. Was decedent pi past 12 months?
hysic	1 Yes 2 No
leted by P	Part II. Other signifi
Somp	
Be	25. Was case referre examiner?
2	1 Yes 2 27. Manner of Death
on:	1 Natural
cati	2 Accident
ij	3 Suicide
	rtification: To Be Completed by Physician/Medical Examin

if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): vents resulting in death) Last AMENDED UNPENDED 23d. Date of delivery F FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? Yes 2 V No Yes No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Yes 2 No

29c. License number

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City

October 14, 2009

29d. Date signed (Month, Day, Year)

or Town, State)

30. Name and address of person who completed cause of death (Item 23a)

Pending

Investigation

Could not be

determined

Assistant Medical Examiner

Due to (or as a consequence of):

111 Penn Street, Baltimore, MD 21201

28e. Place of Injury - At home, farm, street, factory, office building, etc.

31. Date filed (Month, Day, Year)

Donna M. Vincenti, MD

29b. Signature and title of certifier

Homicide 29a. Certifier 1

32. Regiştrar's Signature

State Registrar

James	Darrel	McAllister	
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State of Maryland /	Department of Hea	Ith and Menta	al Hvaiene

dantes Dantel McAll	State of Maryland / Department of He 1-For State Certificate of De Registrar	ooth	Reg. No. 2010 2010
Physician/	Decedent's Name (First, Middle,Last)	2. Date of De Month	Day Year
Medical Examiner	James Darrell McAllister	October 1	10, 2009 131911IS
į	Franklin Square Hospital R	osedale	Baltimore County
Funeral Director			irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
land f show any once.	10a. State MD 10b. County Baltimore 10c. City, Town or Location Essex		10d. Inside City Limits 1 Yes 2 No
ath with the Maryland items 23a or 28a-f sh	1567 Alconbury Rd. Apt. H	21221	10g. Citizen of What Country? USA
Paltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygere. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates:  Armed Forces? If Yes, Sive Year 1 Year 1 Yes, Sive Year 1 Year 1 Yes, Sive Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Year 1 Y	cedent of Hispanic Origin? (Specify Yes or Nepecify Cuban, Mexican, Puerto Rican, etc.)  No specify:	White, etc. White Specify:
215-0036 be filed within 72 hours not all Hygene. rked other than "naturent, the Medical Exam Be Completed I		sual Occupation (Give kind of work done of working life. DO NOT use retired)	16b. Kind of Business/Industry  Construction
1215-0 be filed w ental Hygie orked othe vent, the M	17. Father's Name (First, Middle, Last) George McAllister	18.Mother's Name (First, Middle Bernice King	
MD 21215-0036 nd 2 should be filed within 7 alth and Mental Hygene. m 27 is marked other than raumatic event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print)  Lorissa McAllister/Daughter 481		A3 21691 Burnie, MD
Baltimore, oermit. Pages 1 ar Department of Hee Important: If iter njury or other tr	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition crematory or other to Chesapeak	ce Crem.   Oct.15, 2009	Beltsville, MD
Balt permit. Departi Import injury	The day Sugar Tolk 8717	Green Pastures I	nen D.Lohrmann P.A. Or. Balto, MD 21286
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		rrest, shock, or heart Approximate Interval Between Onset and Death
Jer ,	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	1	
ted nisit Examiner	cause. Enter Unvertising Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):		
760, Toate be executed Toate be in and The burial - transit	X UNPENDED AMENDED 23a, PII, 27, permE	, g897 11/13/09 TT	
68 certif nding se as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal c 4 Pregnant at time of death 5 Other	leath 3 Ectopic pregnancy (Specify)	23d. Date of delivery  Month Day Year
P.O. E es that the igned by the detached	Cocaine use		tobacco use contribute to the cause of death?  'es 2  No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box tat or Attending Physician: The law requires that the death tra after death.  al Director: After this certificate has been signed by the atte lied in by the funeral director, page 2 should be detached for unfification: To Be Completed by Physic			opsy prior to completion of cause of formed? death?
Vital Recc ysician: The lav his certificate ha director, page 2 o Be Comp	25. Was case referred to medical	26.Place of Death (Check only one)	
F Vid Physic or this cal dire	1 Yes 2 No Inpatient 2 ER/Outpatient 3	DOA Other Nursing Home 5 y 28c. Injury at Work? 28d. Describ	Residence 6 Other:
Sion of Attending death. ector: Afte by the funer cation;	1 X Natural 5 Pending 2 Accident Investigation (Month, Day,Year)	1 Yes 2 No	
Division or spiral or Attending spiral or Attending rours after death.  Ineral Director: After filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, f. (Specify)	actory, office building, etc. 28f. Location or Town	n (Street and Number or Rural Route Number, City , State)
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (	23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	in my opinion, death occurred at the time, da	te and place, and due to the cause(s)
<u> </u>	29b Signature and title of certifier  Whentee The Wrell	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 11, 2009
		n Street, Baltimore, MD 21201	
State Registra		Kal	
Driivin 17 Rev 1/2001	ORIGINAL		OGME

09-07914 Joyietta McMath	a	amend Flease Type of Brint in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No.									109 3319			
	Re	For State gistrar			Cer	tifica	te of Deati	h		2. Date of Deat	g. No.	3. Time of Death		
Physician/ Medical Examiner		Decedent's Name (First, N	iddle,Last) LETTA	L.	McMAT	гн				Month October 1	Day Year 1, 2009	1955 hrs		
( )	4a	. Facility Name (if not insti	_	street and number)					Location of					
,4 	_	Bon Secours Hosp	6. Sex	17.400	e (In yrs. Ia	et hirthe	Baltin	er 1 Yea	r If Under	24Hrs 8 Date of Bir	th (MM/DD/YYYY)	A 9. Birthplace (State or		
Funeral Director	L	Social Security Number 8111 218-86-8114	1_1	M 2XF	; (III <b>y</b> IS. Ia		3 Yrs. Month			Min.	/1975	ForeigmARYLAND Country)		
any	_	sual Residence of Deceder la. State 10b. Cou			10c. City,	Town o	r Location					10d. Inside City Limits		
nd show s	м	ARYLAND N	/A			В	ALTIMOR	Е				1 X Yes 2 No		
hite Maryland as or 28a-f sh tiffed at once	10	e. Street and Number	/ 11				10f. Zip			1	0g. Citizen of Wha	t Country?		
h with the Maryl be notified at o eral Direct		1523 CLIFT	ON AV	ENUE				212			U.S.A			
th with it the most t	11	Never Married 2 X	_	12. Was Decedent Armed Forces?		S.	<ol><li>Was Deceder</li><li>If Yes, specific</li></ol>	ent of Hi fy Cuba	spanic Origi n, <b>Me</b> xican,	in? ( Specify Yes or No Puerto Rican, etc.)	14. Race - White,	American Indian, Black, etc.		
er death				1 Yes 2	X No	İ	1 Yes 2	ô No	specify:		Specify:	BLACK		
urs aft tural" amine	$\vdash$	15. Decedent's Education (		or Dates:	pleted)	16a. D	ecedent's Usual	Occupa	tion (Give k	ind of work done	16b. Kind of Busi			
5 72 hor n "ua al Exi		Elementary/Secondary (0	12)	College (1-4 or	5+)	dı	uring most of wo	rking life	e. DO NOT i	use retired)				
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Itani: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	L	12yrs		4yrs		STA	TE OF M	ARYI		Name (First Middle		RESOURCES		
Baltimore, MD 21215-00 permit Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me To Be Com	17	7. Father's Name (First, Mi								s Name (First, Middle,		NSON		
212 uld be Menta marka e even		ADRIAN MULD  a. informant's Name/Rela		pe, Print )		19b.	Mailing Address	s (Stre		ber or Rural Route Nur				
MD d 2 shouth and 12 shouth and 27 is summati	1	Lloyd Jamer	son/H	usband		ĺı	523 Cli	ftor	n Ave.	, Baltimor				
re, land 1 and 1 and Thealt Fitem		Da. Method of Disposition  X Burial 2 Crem			1		Disposition (Na ry or other place		emetery,	Date	20c. Location - 0	City or Town, State		
MOI Pages sent of ant: 1	1	Donation 5 Other		Removal from St		ODLA	WN CEME	TER	7	10-22-09	WQODLAW	N, MARYLAND		
Baltimore, bemit Pages I an Department of Hea Importants II iter njury or other tr.	2	21 Signature of F. neral Service Livinsee  22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL H 1206 W NORTH AVENUE									L HOME P.A.			
	1	3a. Part I. Enter the diseas	Jor Jameli	ications that caused	the death	Do not	1206	W NO	ORTH P	AVENUE				
Physician /Medical	1	failure. List only one c	use on eac	ch line.						,	,	Between Onset and Death		
aminer		nmediate Cause (Final dis r condition resulting in dea		Complication Complication Complication Complication Complication Complete Complete Complete Complete Complete Complication Complete Comple			ı pneum	JIIIa						
*	s	equentially list conditions,	b											
inel	if c	any, leading to immediate ause. Enter Underlying Co	ute _	Due to (or as a cons	equence o	of):								
ied President State of President	e (I	Disease or injury that initia vents resulting in death) L	eo –	Due to (or as a cons	equence o	rf):								
and and	$\vdash$		d	AMENDED 23a, PII, 27, perME, g897 11/17/09 TT										
O, e be es ysiciar burial	L	XUNPENDED FEMALE:					rME, g89	97 1	1/1 <u>7/</u>	09 TT	23d. Date of d	delivery		
). Box 68760, the death certificate be experienced for use as the burial cached for use as the burial Physician/Medic	23	ib. Was decedent pregnan past 12 months?	in the	23c. If yes, outco	ine or preg	2	Fetal death	3	Ectopic	pregnancy	Month	Day Year		
Box 6 c death cer the attend ed for use	1	Yes 2 No 9	Unknown	4 Pregnant a	time of de	eath 5	Other (Spe	ecify)			1	1		
s, P.O. Be inters that the dear signed by the set detached for the bed by the bed by the by by year by Physes	-	art II. Other significant co			h but not r	esulting	in the underlyin	ng cause	given in Pa	art I. 23e. Did	tobacco use contrib	bute to the cause of death?		
P.O. es that the igned by be detach		Hypertensiv	re ath	neroscler	otic	car	diovascu	ılar	dise	ase 1 Ye	es 2 🗸 No 3	Probably 4 Unknown		
of Vital Records, P.( ng Physician: The law requires tha ther this certificate has been signed nureal director, page 2 should be det no. To Be Completed by										24a. Was		Vere autopsy findings available rior to completion of cause of		
e law te has ge 2 st		<u> </u>								perf	ormed? d	eath?  Yes 2 No		
tal Rection: The certificate ector, page		5. Was case referred to m	edical	<del>.</del>				26.Pla	ce of Death	(Check only one)				
Vital I ysician: this certifi director,	)	examiner? 1 ✓ Yes 2 No		lospital: 1 Inpati	ent 2 🗸	ER/O	utpatient 3	DOA	Other <sub>4</sub>	Nursing Home 5	Residence 6	Other:		
1 of Vit ling Physic After this funeral dir	- 12	7. Manner of Death		28a. Date of Inj (Month, Day,	ury Year)	28b. 7	Time of Injury	i	jury at Work	_	how injury occurre	ed		
ivision or Attend after death Director: I in by the i	ξĮ.	2 Accident	Pending Investigation	on St (1			f		Yes 2		(Street and Number	er or Rural Route Number, City		
Division o repiral or Attending hours after death. meral Director: Aft y filled in by the fund Certification:		3 Suicide 6	Could not be determined	oe	njury - At r	iome, ta	rm, street, factor	гу, опісе	e building, e	or Town,		or Naral Nodic Nambor, Ony		
		Homicide  9a. Certifier 1 Certifyl	ng Physicia	an: To the best of n	ny knowled	dge, dea	ath occurred at the	ne time.	date and pla	ace, and due to the car	use(s) and manner	as stated.		
To the Hoo within 24 h To the Fur completely		Check only 2 Medica	Examiner	On the basis of exa	mination a	and/or in	nvestigation, in n	ny opini	on, death or	ocurred at the time, dat	e and place, and d	ue to the cause(s)		
£ 600 E.≥ E. S. B. S.	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed							ed (Month, Day, Year)						
		D_M	,	-				0.0	C.M.E.		October 12	., 2009		
	3	0. Name and address of p					111 Page	Chro	at Raltim	ore, MD 21201				
Circle	3	Donna M. Vincent  1. Date filed (Month, Day,)		Assistant Medi				. 5000	or, Daitiiii	OIG, WID 2 1201				
Registra		nct-1	6 200		بربه	1.	parkel							

DHMH 17 Rev 1/2001

OCME

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 10:10 A ROGER EDWARD MARTIN OCTOBER .3 , /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2309 Shannon Road Edgewood Harford 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 11XM 2□ F Months Days Hours Min Director 226-58-9257 63 1946 16, Virginia Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show event, the Medical Examinar : ust be notified at 1 ☐ Yes 2 🛣 No Director Maryland | Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 2309 Shannon Road USA Funeral 21040 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White 1 ☐Yes 2 🛛 No ğ 3 Widowed 4 Divorced Year or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Combat Engineer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Wilson Martin Inis Luvine Testerman ပ Pages 1 and 2 should or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any Injury or other trau once. Geraldine Martin / Wife 2309 Shannon Road, Edgewood, Maryland, 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 10/15/2009 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. En or the increase, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard faire. List only one cause on each like Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0063981

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Baltimore, Maryland 21215-0036

State

Revolution St. Havre de Grace, MD

21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

669

Benjamin Y.

31. Date filed (Month, Day,

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death Month October

10, 2009

4c. County of Death

10601 River Road Potomac 5. Sc **Funeral** 07 Director Usua Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. r items 23a or 28a-f show free rust be notified at Be Completed by Funeral Director Ma 10e. 11. N Baltimore, Maryland 21215-0036 3 Ele 17. F permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 Is marked any Injury or other traumatic evone. ٩ 19a. L 20a. 21. 5 23a. **Physician** /Medical Examiner Sequif any caus Caus that i resul Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

10601 River R		Potomac					Montgomery				
5. Social Security Number		7. Age (In yrs. la	ist birthday)	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year	9. B	irthplace (State or Foreign Country)	
070-12-2265	1 □ M 2 🔀 F	86	Yrs.	World Days	110013	1411().	January	12,19	923 Gei	rmany	
Usual Residence of Decedent											
10a. State 10b. County	′	10c. City,	Town or Lo	cation						10d. Inside City Limits	
Maryland Mont	gomery			Poton	ac					1 □ Yes 2 🖾 No	
10e. Street and Number				10f. Zip Code				10g. C	itizen of What 0	Country?	
10601 River	Pond			2085	54			11.	nitad S	tates	
11. Marital Status	12. Was Dece	dent Ever in U.S	. 13. \			rigin? (Sp	ecify Yes or No		nited States  14. Race - American Indian,		
1 ☐ Never Married 2 ☐ Mar	Armed For			Was Decedent of f Yes, specify Cu	oan, Mexica	an, Puerto	Rican, etc.)		Black, Wh	ite, etc.	
3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv	е	1	I∐Yes 2⊠XNo	Specify	<b>/</b> :			Specify: White		
15 Decede	nt's Education		16a Decer	dent's Usual Occi	nation			16b k	Cind of Busines	s/Industry	
(Specify only highe	est grade completed)	- 1	(Give life, L	kind of work done  OO NOT use retire	during mo	st of work	ing	-			
Elementary/Secondary (0-12)	College (1-	4or 5+)	Homem		/			Otan	Home		
17. Father's Name (First, Middle)	Last)		Homen	ance	18 Moth	ner's Nam	e (First, Middle			<u>-</u>	
Yonegi Inaza					101,710.		rietta				
19a. Informant's Name/Relations			19b Mailin	ng Address (Stree	t and Num					Zin Code)	
Linda Stone/Da			l					-		ryland 20878	
20a. Method of Disposition		20b Pl				50011	Date		ocation - City o		
1 ☐ Burial 2 X Cremation		nate i		sition (Name of natory or other pla		Octo		_			
4 Donation 5 Other (5		Montg		rematorium						Maryland	
21. Signature of Funeral Service	inn W	M013	05 Roc 300	bert A. Pu West Mon	ess of Faci mphrey tgomer	Funer Y Aven	cal Home, nue, Rock	Rock Ville	ville, I	nc. nd 20850-2805	
23a. Párt1. Enter the disease, o shock, r heart failure. Lis	r complications that ca t only one cause on ea	used the death. ach line.	Do not ente	er the mode of dy	ing, such a	s cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)	a			ive Lun	g Dise	ease				5 Years	
,	Due to (	or as a conseque	ence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (	or as a conseque	ence of):								
that initiated events	С.										
resulting in death) Last	Due to (	or as a conseque	ence of):								
	d										
IF FEMALE:											
23b. Was decedent pregnant		ome of pregnar irth 2  Fetal		Ectopic pregnar	icv			1	23d. Date of c	·	
in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		ant at time of de		Other (specify)	<u>.</u>				Month	Day Year	
Part II. Other significant conditi	one contributing to do	ath but not rocul	ting in the ur	odortvina couco a	von in Port		23a Did	tobacco	use contribute	to the cause of death?	
Atrial Fibril			-					Yes 2		Probably 4 🗍 Unknown	
		<u>r</u>		J F							
							24a. Was	nsv	prior to	autopsy findings available ocmpletion of cause of	
							perf	ormed? 2 X N	death' o 1 □ Ye	? es 2 □ No	
25. Was case referred to medica	ıl				26. Plac	e of Deat	h (Check only				
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 □ II	npatient 2 E	R/Outpatien	it 3 □ DOA O	hor:				6 ☐ Other (Sp	pecify)	
27. Manner of Death	28a. Date o	f Injury	28b. Time of		ury at		28d. Describe				
1 🕅 Natural 5 🗔 Pendii 2 🔲 Accident investi	ng ( <i>Monti</i> igation	h, Day, Year)	Injury		ork? ⊒Yes 2.[	]No					
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ninge   28e. Place	of Injury - At hor	ne, farm, stre	et, factory, office						Rural Route Number,	
4 LI Nomiciae	Dullait	ig, etc." (Specify,	,				City or To	wn, Stat	re/		
29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the Examiner: On the ba and mann	isis of examinati	rledge, death on and/or in	n occurred at the vestigation, in my	time, date a	and place, eath occur	, and due to the red at the time	e cause( , date ar	s) and manner nd place, and d	as stated. ue to the cause(s)	
29b. Signature and title of certifie				29c. Licer	se number			29d. D	ate signed (Mo	nth, Day, Year)	
· Made	9× W			D	29229			0ct	ober 12	2, 2009	
30. Name and address of person Martin Kanovsk					#70	O. CH	nevv Ch	ase	Marvla	and 20815	
31. Date filed (Month, Day, Year,					, ", "	, 01	2019 011	400,	11GE y 16	20015	
OCT 16	2009 Cen	egistrar's Signar	1400	A							

Registrar DHMH 17 Rev 1/2001

State

10

3. Time of Death

 $P^{M}$ 

9:50

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar

**Physician** 

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

Liesa I. McFadden

4a. Facility Name (If not institution, give street and number)

Pleas

se Type or Print in Bla	ck Indelible Ink.	Ensure A	II Copies A	re Leg	jib
State of Maryland /	Department of H	ealth and N	Mental Hygie	ne 🗀	U
	Certificate of E	Death	Reg	. No.	
, Last)			2. Date of Death Month	Day	,

33195

Physic /Medi Exami

Funera Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, Ira Macitcal Examiner must be notified at agnee.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, 20 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

St Regis

	for State Of W	•		cate of L		Wientan Try	Reg. No.	have high and				
	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death			
ian cal	Harry G. Muller,	Jr.				Octobe		2009	12:30 A <sup>M</sup>			
ner	4a. Facility Name (If not institution, give street and number	)	4b. (	City, Town, or	Location of Dear	th	4c. C	County of Death				
	Montgomery General Hospita			01n	-			ntgomer				
	. What o□ =	ge (In yrs. last bir	thday) If U Yrs. Mor	nder 1 Year iths Days	If Under 24 Hrs Hours Min		th iv, Year)	9. Birth	place (State or Foreign intry)			
	579-16-2593	87	110.			July 2	0, 192	ZZ Wasiii	ngton, D. C.			
	10a. State 10b. County		10d. Inside City Limits									
ţ	Maryland Montgomery	Sil	ver Sp	ring					1 □Yes 2 🗓 No			
irec	10e. Street and Number		10	. Zip Code			10g. Citiz	en of What Cou	intry?			
a D	3367 S. Leisure World Blvd	l., #2B		2090	6		Unit	tes				
ner	11. Marital Status 12. Was Decedent Armed Forces	4. Race - Amer Black, White,										
Be Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☑ Married 3 ☒ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☑ No WWII If Yes, Give 11. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race Black  15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  16. Yes, Specify.  17. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								Hite			
pleted	15. Decedent's Education (Specify only highest grade completed)	d of Business/Ir	ndustry									
mo;	Elementary/Secondary (0-12) College (1-4or	As	socia	tion E	xecutive	!	Non-	Profit	Organization			
ge C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden S	Surname)				
2	Harry G. Muller, Sr.				Eliza	beth Lau	ıterba	ach				
ľ	19a. Informant's Name/Relationship (Type. Print)	1.0	_			iural Route Numb						
	Christine M. Pulford/Daug					d, Woodb						
	20a. Method of Disposition  1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of cemeter  Montgome			_ : 000	ober 10, 2009		esda, M				
	21. Signature of Fundal Service Licensee	M01305	Rober 300 W	t A. Purest Mont	ss of Facility mphrey Fur	neral Home	/Rockv	ville, In Marylan	c. d 20850–2805			
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do							Approximate Interval Between			
	Immediate Cause (Final disease or condition		Onset and Death									
	resulting in death)	s a consequence	of):	7					~			
Ι, Ι	Sequentially list conditions b. : UI	Mau	1 12	act	INFE	bar	7					
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):											
хаш	Cause (Disease or Injury that initiated events resulting in death) Last C				1							
a E	530 10 (61 2	o a consequence	01).									
dic	0.											
ZMA	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome the state of the state o	3d. Date of deli	verv									
icjai	in the past 12 months?	Month	Day Year									
hys	9 Unknown											
Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death	but not resulting in	n the underly	ing cause giv	en in Part I.		tobaccous Yes 2[⊾		the cause of death?			
etec	111/00					24a. Was	on	24h Word aut	topsy findings available			
ldm	- civere cut	1 Cl	1			auto		prior to c	completion of cause of			
	25. Was case referred to medical	nal	pal	In	0	1 □ Yes	2 1110	1 ☐ Yes	2 🗆 No			
) Be	examiner?  1 Yes 2 Mo  Hospital: 1 Pringa	tient 2 ER/Ou	stactiont 2	J DOA Oth	0.51	eath (Check only Home 5 Res		Othor (Case	26.4			
ΞŢ	27. Manner of Death  1. Dentatural 5   Pending (Month, D.		Time of	28c. Injur Work		28d. Describe			ліу)			
atio	1 ☑ Natural 5 ☐ Pending (Month, L 2 ☐ Accident investigation	ay, Year) I	njury M		<br Yes 2 □No							
Medical Certification: To	0.000	njury - At home, fa	rm, street, fa	ctory, office		28f. Location City or To	(Street and wn, State)	d Number or Ru	ral Route Number,			
al Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis											
edic	one) and manner s		iu/or investig			oureu at the time						
2	29b. Signature and title of certifier	46		29c. Licens			29d. Date	e signed (Month	i, Day, Year)			
	M COCOLS C			41	1850			10/8/	109			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HECHNEY (OVUZO)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  OCT 1 6 2009											
	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	8101	100	VILE +	VILLE	Wr.	UINE	4,70			
ate irar	OCT 16 2009	1. 10	What I						-/			

			For Amend Item State Registrar	s State of Marylar	ad / Departme Certifica	716/ <b>793</b> HB and I te of Death	Mental Hygier Reg. I	ne vo. 2009	1319	
Phys	sicia	n	1. Decedent's Name (First, Middle, La	-			2. Date of Death Month	Day Year	3. Time of Death	
_	dica			aurin, Jr.				12009	03:12 PM	
Funer Direct	ral		4a. Facility Name (If not institution, given the second security Number 6. S. Social Security Number 6. S. Social Residence of Decedent	lman Kd	. 0	y, Town, or Location of Death  A Thurbury  er 1 Year If Under 24 Hrs.  Days Hours Min.	8. Date of Birth (Month, Day, Yes	Gunty of Death  O. British  O. British  O. British  O. British  O. British  O. British	place State or Foreign	
land ow	,	Ì	10a. State 10b. County	10c. C	My Town or Location			1	lod. Inside City Limits	
Mary a-fsh	.	혅	Ma	1 VE	altemb	1)			1 Pres 2 □ No	
death with the Maryland ims 23a or 28a-f show	1	Funeral Director	10e. Sheet and Number 2823 Doll	nas, Rd	10f. Z	ip Code 2/225	10g. (	Citizen of What Cour	ntry?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Macical Examinations in any injury or other traumatic event, Its Macical Examinations.		2	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ⊒Yes 2 □ No /9, If Yes, Give Year or Dates: /9	13. Was Dec If Yes, sp 1 ☐ Yes	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 PNo Specify:	pecify Yes or No- Bican, etc.)	14. Race - Americ Black, White, Specify:		
ZTZTS-( ZTZTS-( ed within 72 ho /giene. er than "natu ;, IT M oferl		Completed	15. Decedent's Et (Specify only highest gra Elementary/Specifically (0-12)	ducation ade completed)  College (1-4or 5+)	16a. Decedent's Us (Give kit)d of w life. DONOT	ual Occupation ork done during most of work use refired)	ing 16b.	Kind of Business/In	dustry	
Maryland  of 2 should be file th and Mental Hy 77 Is marked othe r traumatic event,	i	To Be (	17. Fayler's Name (First, Middle, Lagt,  OM UL  19a, Informant Name/Relationship	Lauren	Sr.	Maci	e (First, Middle, Maid	all		
S 1 and 2 sl of Health an item 27 Is of			20a. Method of proposition	in/Wife 30h)	2823 O	(Street and Numb) Hip All Max X me of other place)	d Dalty	y or 70 wn, State, 211 yocation - City or To	12/225	
<b>SAITIMORE,</b> permit. Pages 1 ar Department of Hez Important: If item any injury or othe	once.		1 ☐ Burin 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification) 5 ☐ Signature of Funeral Service Alger	Hemoval from State	www.	and Address of Facility	19/09 C	rbutus eral Se	wice	
1 2.0 E %	a	_	/wrellx).	Gar 82.	1018	izabeth Hi	4 Salt	Maa	1/200	
Physicia /Medic	al		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	is cell car	de of dying, such as cardiac			Approximate Interval Between Onset and Death  5.5 years	
fficate be executed ficate be executed by physician and stree burial-transit		edical Examiner	Sequentially list conditions, if any, reading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect  Due to (or as a consect  d.						
ath certifications attending for use as		Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn.  1  Live birth 2  Feta 4  Pregnant at time of a	al death 3 Ectopic			23d. Date of delive Month	ery Day Year	
quires that the de an signed by the a	ž	Part II. Other significant conditions continuous to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death  1 □ Yes 2 □ No 3 □ Probably 4 ☒ Unkr		
Physician: The law requires trins certificate has been signeral director, page 2 should be or	Complet	Сотріете	Prostate can	cer		1.1.00	24a. Was an autopsy performed? 1 □ Yes 2 ☑	prior to co death?	psy findings available impletion of cause of 2  No	
sician: Th certificate rector, pag	á	ם	25. Was case referred to medical examiner?	Hospital:		26. Place of Deat	h (Check only one)			
ding Phys h. After this funeral dir	ion: T	IION: 10	1 ☐ Yes 2 ☑No  27. Manner of Death  1 ☑Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	BR/Outpatient 3 D 28b. Time of Injury	OA Outler. 4 Nursing Ho 28c. Injury at Work? 1 Yes 2 No	ome 5 🛮 Residence 28d. Describe how in		(y)	
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	Cortification	Cerumoa	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				28f. Location (Street City or Town, Sta	and Number or Rura ate)	al Route Number,	
the Hospith hin 24 hours the Funera mpletely fille	legipo	ealical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysiclan: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigatio	d at the time, date and place n, in my opinion, death occur	, and due to the cause red at the time, date a	e(s) and manner as s and place, and due to	stated. o the cause(s)	
To t with To t	M		29b. Signature and title of certifier	nn	29	C. License number		ober 16,		
			30. Name and address of person who			itany Cir	ch Ellia	off City 1	4D 21043	
Regi:	State strar		31. Date filed (Month, Day, Year)	2019 Ceneva	ature S. San	NE P				

DHMH 17 Rev 1/2001

Roland Maynerd		ield, Jr. S	State of Mary	land / De	epartment Certificate			Menta	al Hyg		on No		110 2210
Physicia		Registrar 1. Decedent's Name (First, Mic	Idle,Last)		, , , , , , , , , , , , , , , , , , ,					Date of Dea	ath	Year	3. Time of Death
Medical Examir	ner	Roland May	nard Ne	ifeld	, Jr					Month October			0728 hrs
(,		4a. Facility Name (if not institu 8808 Old Harford Ro		number)			y, Town, or L rkville	ocation of			Balt	imore Co	ounty
Funeral Director		5. Social Security Number 2 1 2 - 7 6 - 9 0 1 6	6. Sex		rrs. last birthday	_	Inder 1 Year Inths Days	If Under Hours			irth(MM/DD/ 28,19	Fore	Birthplace (State or eig/Maryland Country)
y		Usual Residence of Decedent 10a, State 10b, Count		1100	City, Town or Lo	ocation							10d. Inside City Limits
d tow any			, Baltimor		01()  10 0. =.		arkv:	ille					1 Yes 2 X No
aryland 8a-f sh	Director	10e. Street and Number				10f.	Zip Code				10g. Citizen	of What Co	ountry?
vith the Maryland 2.23a or 28a-f show s notified at once.		8808 Old Ha	arford R	oad		2	1234				US	SA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 X	Married Armed		No I	If Yes, sp	edent of Hisp ecify Cuban,	Mexican,				White, etc.	erican Indian, Black, Phite
rs afte ural",	ā	Widowed 4 15. Decedent's Education (S	Divorced If Yes, Give Yor Dates:		d) 16a Dece	Yes edent's Us	ual Occupati	specify: on (Give ki	ind of wo	rk done		of Busines	ss/Industry
72 hou n "nat	etec	Elementary/Secondary (0-1		(1-4 or 5+)	durir	_	working life.			d)	Sol	lf Em	ployed
5-0036 Ted within 7 Hygiene. Other than	Completed	12			VIC	chei	Des:			Tinak Kalabala	, Maiden Su		—————
215-( be filed v ntal Hygi rked oth	Be Cc	17. Father's Name (First, Midd Roland Ma)		ifeld	Sr				,		loway		
212 212 213 214 215 215 215 215 215 215 215 215 215 215	8	19a. Informant's Name/Relation	onship (Type, Print )		19b. M			t and Numb	per or Ru	ral Route N	umber, City	or Town, St	ate, Zip Code)
MD d 2 sho lth and n 27 is		Cynthia Ne	ifeld-sp							Road- Date			or Town, State
MOFE, Pages I an nent of Hea ant: If iter		20a. Method of Disposition  1 Burial 2 Cremal  4 Donation 5 Other		I from State	crematory Evans F	sposition or other pl unera	ace) al Cha nSVR I	pel pel	oct. 1	4,20 <i>0</i>	7 Fore	est Hi	ill, Maryland
Baltil permit. 3 Departm Importa		21 Stonature of Funeral Serv	ice Licensee		1	<ol> <li>Name</li> </ol>	and Address	of Facility					
		23a. Part I. Enter the disease	TI for	old-	teath Do not er	-Xans	Harto	ord Ro	oad-	Parky Parky	Trest, shock	aryla or heart	Services nd 21234 Approximate Interval
Physician √Medical		failure. List only one cau	use on each line.			ner the m	out of the state o	00017000		,	•		Between Onset and Death
aminer		Immediate Cause (Final disea or condition resulting in death		s a conseque									
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	nine	if any, leading to immediate cause. Enter Underlying Cau	ise	is a conseque	nce of):								
ansi:	Examiner	(Disease or injury that initiate events resulting in death) La		is a conseque	nce of):								
be executed ician and irial - transit	dical	UNPENDED	AMENDE	D									
68760 certificate b tding physise as the bu	ian/Med	IF FEMALE: 23b. Was decedent pregnant i	- 46 -	es, outcome of ve birth		Fetal d	eath 3	Ectonic	pregnan	ıcv		Date of deli Nonth	very Day Year
x 68 h certif tending use as	ပ	past 12 months?	4 Pr	egnant at time	of death 5		(Specify)	Lotopio	, program				•
of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate the After this certificate has been signed by the attending physituneral director, page 2 should be detached for use as the broaden of the control of the	hysi	1 Yes 2 No 9	90	known		Alexander	duin - course	-ivon in Bo	urb I	23e Di	d tobacco us	se contribute	e to the cause of death?
P.O.	by P	Part II. Other significant cor	ditions contributin	ig to death but	not resulting in	the unde	Tying cause	givenin Fa	ii (				Probably 4 Unknown
ds, I		-								24a. W			e autopsy findings available
COLOR Is law re has be e 2 sho	ompleted			<del></del>						pe	topsy rformed? s 2 No	deat	-
of Vital Records,  ng Physician: The law requir the this certificate has been s neral director, page 2 should I	C	25. Was case referred to med	tical	-	<del>.</del>		26.Plac	e of Death	(Check o		S Z NO		Yes 2 No
Vita ysiciai his cer directo	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 ER/Outp	atient 3	DOA	Other <sub>4</sub>	Nursing	Home 5	Residen	ce 6 🗸 C	Other: Scene
n of ding Ph.	on: T	27. Manner of Death	28a. D	ate of Injury onth, Oay,Year) ND:		ne of Injur		ry at Work	lr lr		be how injur		-
Division tal or Attendi rs after death. al Director: A	atio		nvestigation Oct 1	12, 2009	FOUNI 0720 h	rs		Yes 2 ✔	No				or Rural Route Number, City
ivis lor A after Direction by	ertificati		Could not be	Place of Injury cify) Single	- At home, farm	ı, street, fa	ictory, office	building, et	tc.	281. Location or Town	n (Street an n, State) Iarford Roa	o Numbero ad Parkv	ille. MD
Division of Vital Records, P.O. Box 68760 within 24 bus after death certificate by within 24 buss after death. To the Junearia Bracedar. To the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the business.	ပ	29a. Certifier (Check only 1 Certifyin	g Physician: To the Examiner: On the ba	best of my kn	owledge, death	occurred	at the time, d	late and pla	ace, and	due to the o	ause(s) and	manner as	stated.
To th withir To th compl	Medical	29b. Signature and title of ce	and mann		audit allu/or litve	Jouganon	29c. Licen						(Month, Day, Year)
	_	Theto Ella	the f	eek	1980			.M.E.		· <del>**</del>		ber 13, 2	
(4)		30. Name and address of per Victor Weedn MD		cause of death		11 Per	n Street,	Baltimor	e, MD	21201			
	tate	31. Date filed (Month, Day, Ye	ear) /32	2. Registrar's S	Signature								
Regis	trar	OCT 16	2009 Bu	may	8. pa	plas							
DHMH-17 Rev 1/2	2001		001		ORIO	SINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #17 pe rfH G896 10/23/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician October 45AM Kubi Newman 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Nursing Home HY LI NO HON Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 74 Director 224-38-6094 Virginia Oct 18, 1934 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Evantiner must be notified at once. Director 1. Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5937 St. Regis Road 21206 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: ፩ 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Unknown Williams 2 Agnes Ruffin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Berry /Daughter 5937 St. Regis Road Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 16 4 ☐ Donation 5 ☐ Other (Specify) 2009 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ste **Physician** End disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No 1 □Yes 9 Hospital or Attending Physician: 24 hours after death.
9 Funeral Director: After this certifical director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) NURSE PARCTION and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R120622 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3601 0'Donnell 5't Baltimus MD 2)224 PATRICK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

16 2009

			For State Registrar	State	of Mary		•	tment of F <i>ficate of</i> .		Mental Hyg	jiene leg. No		5319
	D!		1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		JAMES	W.		O'GOR	MAN			OCTOBE		2009	12:30 AM
	Examin		. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death									inty of Death	
age.			GOOD SAMARITAN	NURSING	HOME			BALTI				J/A	
d.	Funeral		5. Social Security Number	6. Sex 1 <b>∑</b> M 2 ☐ F	7. Age (I	In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	9. Birth	place (State or Foreign ntry)
ı,	Director		215-09-8239	TLALIVI ZLIT	9	91 Y	rs.			8/30/1	918	MARY	LAND
	and w		Usual Residence of Decedent  10a, State 10b, County		10	Oc. City, Town	or Locat	tion				1	I0d. Inside City Limits
	Maryl f sho	ō	MD BAL	TIMORE		PERR	V U	١٢٢					1 ∐Yes 2 🛣 No
	the 1	Director	10e, Street and Number	THORE		1 Ditt		10f. Zip Code		1.	I0g. Citizen	of What Cour	ntry?
	3a or		13 PERRYFALLS	DI ACE				2123	6			TC A	
	ns 2	Funeral	11. Marital Status	12. Was De		er in U.S.	13. Wa	e Decedent of E	lienanic Origin? (	Specify Yes or No-		JSA Race - Ameri	can Indian,
٩	or Ite		1 ☐ Never Married 2 ☐ Marr	ied Armed F	Forces? 2 ∐ No Bive		If Y	es, specify Cuba -	an, Mexican, Pue	rto Rican, etc.)		Black, White,	etc.
5-0036	ral", c	by	3 Widowed 4 ☐ Divorced	Year or		WII	'L	JYes 2 Ar No	Specify:		Spe	ecify: WH	ITE
ე- ე-	within 72 hours after death with the Maryland lene. Itan "natural", or Items 23a or 28a-f show hu hedical Ezoniner must be notified at	Completed	15. Deceden (Specify only higher	t's Education	<del>d</del> )			nt's Usual Occup	oation during most of wo	orkina	16b. Kind o	f Business/In	
7	ithin nan "	du.	Elementary/Secondary (0-12)	ī	(1-4or 5+)		life. DO	NOT use retired	d)				
. ч	filed w Hygier sther th		12TH GRADE			HV	HC S	SERVICE	TECHNIC		HVAC		
ב	e d ala	Be	17. Father's Name (First, Middle,	ŕ					18. Mother's Na	me (First, Middle,	Maiden Suri	name)	
Maryland	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	မ	FREDERICK O'GO							E. HUNICH			
<u>a</u>	12 sh h and 7 is n traun	5 4	19a. Informant's Name/Relations			1				Rural Route Numbe	r, City or To	wn, State, Zij	o Code)
o)	1 and 2 Health Pm 27 ther tr		DONALD O'GORMAI	V/SON					S PLACE	PERRY H	ALL, N	1D 212 on - City or To	236
Ö	ges nt of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from		cemetery MD VET	Dispositi ∕, cremat 'Γ'DΛN	on (Name of tory or other place IS CEMET	ce) PEDV	Date	20c. Localii	on - City or 10	own, State
altimore,	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (S			EASTER			1 10	16/2009	HURLO	OCK, MI	)
g	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service	Licensee MO	n39°					HE JOHNSO			
			23a. Part 1. Enter the disease, or	Jago V	por	dooth Door				BLVD. TO		WD 2	1286 Approximate
		, , ,	shock, or heart failure. List	only one caus on	each line.	e deam. Donc	1		also:	ac or respiratory an	est,		Interval Between
-	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. #	7 /20	ma		m	8				Sheet and Dath
	/Medical Examiner		resulting in dealiny	Due to	(of as a co	onsequa ce of	<del>f):</del>	,					week.
	- 19	<u>.</u>	Sequentially list conditions,	b	erne	Unicequence of	1						
7	rted nsit	nin.	if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events	500 1	0 (0) 40 4 0	onecquence or	17.						
)	executed n and al-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a co	onsequence of	f):						
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X OX	n certii inding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o							23d.	Date of deliv	rery
ň	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pre	egnant at tin	☐ Fetal death ne of death		Ectopic pregnanc Other <i>(specity)</i> _	у			Month	Day Year
)	the control	hysi	9 ☐ Unknown	9 □ Uni	known								
7.	law requires that the death certificase been signed by the attending to 2 should be detached for use as	by P	Part II. Other significant condition	ons contributing to	death but n	ot resulting in t	the unde	erlying cause giv	en in Part I.	23e. Did to	bacco use o	contribute to t	he cause of death?
ecords,	quire									. 1□Y	es 2□N	o 3∏ Pro	bably 4 HUnknown
ပ္ပ	s bec	lete								24a. Was a	an 24	4b. Were auto	opsy findings available
Y Y	The la te ha age 2	Completed							-	autop perfor	med?	death?	ompletion of cause of
VITA	an: ] tiffica for, p	Be C	25. Was case referred to medical						26. Place of De	1 ☐ Yes eath (Check only or	<del></del>	1 ∐Yes	2 No
>	Physician: The law r this certificate has b ral director, page 2 sl	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	7 Inpatient	2 🔲 ER/Outp	patient	3 □ DOA Oth	or:	Home 5 ☐ Resid		Other (Sneci	(fv)
0	g Ph ter th	Ë	27. Mann of Death	28a. Dat	e of Injury onth, Day, Ye	28b. Tii		28c. Inju		28d. Describe h		1 - 1 - 1	.,,
0	ath. r: Aff	atio	1 V Natural 5 ☐ Pendin 2 ☐ Accident investig	9	onui, Day, re	ear) iii	jui y		N:  Yes 2∐No				
UIVISION	Atte	iţi	3 ☐ Suicide 6 ☐ Could in determined	ined   28e. Plac	ce of Injury	- At home, fam	m, street	t, factory, office		28f. Location (S City or Tow	treet and No	umber or Run	al Route Number,
5	talor safte al Dii	Certification:		20.11	ang, our (	-p				Only or Tow	ii, ciaro,		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only 2 Medical	ng Physician: To the Examiner: On the	he best of n	ny knowledge, kamination and	death o	ccurred at the ti	ime, date and pla	ce, and due to the	cause(s) and	d manner as	stated. to the cause(s)
	the hin 24	Medical	one)	and ma	anner stated	i.							
	<b>7</b> with	2	29b. Signature and title of certifie	K. Tr	Re	uar	~	29c. Licens	se number		29d. Uate si	gned (Month,	gay, Year) In 2009
	, , ,		Much	( )				100		^	00-		ac )
	H+1		30. Name and address of Jerson	who completed ca	use of pleat	h (Item 23a) (T	Type, Pri	monst	· Ma	1 - 212	239	· .	
	77 - Cla	t o	31. Date filed (Month, Day, Year)	32	Registrar's	Signature	Levil		100				
	Sta Registra		OCT 1 6 2009	Resura	A.	back	May !						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Michae Pirone 842 AM Kichard 10 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Columbia Howard HOSP ital Howar County (reneral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 05/08/1943 9. Birthplace (State or Foreign 6. Sex 1**X** M 2 □ F Days Hours Min. New York 112-34-9296 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Ellicott City MD 1 Nes 2 No Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A. 8632 Trail View Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2X Married Specify: White Army 1 ☐Yes 2K No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Restaurant Owner 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucy Mucci Ernest Pirone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Raltimore. MD 21210 19a. Informant's Name/Relationship (Type. Print) 6003 Hunt Ridge Road, Baltimore, MD Cary Pirone/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Ardent Cremation Services 10/15/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services Laura C. Hardesty 7522 Connelley Drive, Ste.N, Hanover, MD 21076 M01197 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final overdov 12 hour disease or condition resulting in death) Due to (or as a consequence of): Suitiale 12 hours Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 1 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident

**Examiner** and Box 68760, P.O. Division of Vital Records,

or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Completed by Physician/Medical Certification: To

3 Suicide

29a. Certifier

4 Homicide

Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 Is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 Is marked

any injury or

Physician

/Medical

Baltimore, Maryland 21215-0036

other traumatic event, the Madical Examinar must be notified at

**Funeral Director** 

Be Completed by

P

Be

Medical

the Hospital

State Registrar 29b. Signature and title of certifier

6 □Could not be

determined

930 PM 1 🗆 Yes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence

00066515

intentional overdose of medication 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8632 Trail View Drive, Ellicott City

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

M.D

5 5 eday

10 2007 Columbia MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) owat

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** WILBUR MONROE PENLEY OCTOBER 4. 2009 2:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1 ☑ M 2 ☐ F Director 017-24-6026 21. 1932 New Jersev Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show event, the Medical Examinar must be notified Director 1 ☐ Yes 2 ☑ No Maryland | Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 301 Willrich Circle 21050 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or items 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. \$ 3 Widowed 4 Divorced Maryland 21215-003 'natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Insurance Auditor Auto Auction 7 is marked other traumatic event, if 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be theatth and Mental Harold Clark Penley ပ Myrtle Mae Herrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Willrich Circle, Forest Hill, MD 21050 Jean H. Penley / Wife 27 Department of Heal Important: If item 2 any Injury or other once. other 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion U.M.C. Cem. 10-17-09 Bel Air, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ad **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner days 91 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner dsu burial-trar that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Ye ar Month 5 Other (specify) 9 Unknown that the signed b I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 800270615 Division of Vital 2  $\square$  No 1 ∐Yes 2 X No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) . Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the course of the course o completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one within 2 the

State Registrar

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DHMH 17 Rev 1/2001

29b. Signature and title

30. Name and address of

Kapi Kurbar 31. Date filed (Month, Day, Year)

No

rate

32. Registrar's Signature ORIGINAL

person who completed cause of death (Item 23a) (Type, Print)

M.D. 5004

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of M	larylan	-	artmen <i>rtificate</i>			and M		iene g. No.		1.33262
	Physici	212	1. Decedent's Name (First, Midd	le, Last)							Date of Deat     Month	n Day	Year	3. Time of Death
	Physici /Medic		Melonee Pla								OCTOBER		2009	12:35 AM
	Examin	er	4a. Facility Name (If not institution	-	•		4b. City,		r Location o			4c. Co	unty of Death	
The same			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth										I a Birth	place (State or Foreign
н	Funeral Director		218-62-3317	1 M 2 1 F 7. A	.ge ( <i>III yis. 1</i>	Yrs.	Months	Days	Hours	Min.	(Month, Day,		Mary	ntry)
			Usual Residence of Decedent						1, ,		May 0,		riary	Land
	how	_	10a. State 10b. County		10c. City	, Town or Lo	cation						1	10d. Inside City Limits
	e Ma Ba-f s	cto	MD Baltin	nore	Ва	altimo	re				4			1 □ Yes 2√√ No
	ath with the Marylan s 23a or 28a-f show	i di	10e. Street and Number 6525 Brown Ave				10f. Zip	Code 2122	) /.		11	og. Citizen US	of What Coul	ntry?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinat rough to modified at	Funeral Director		12. Was Deceden	Francis III	D 112				min 2 /Cm	anifu Van or No		Race - Ameri	ean Indian
10	ter de item	E L	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	Armed Forces	7	5.   13.	If Yes, spec	ent of F	an, Mexican	gin (Spi , Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
036	urs af	þ	3X Widowed 4 □ Divorced				1 □ Yes 2	2 <b>∏</b> No	Specify:			Sp	ecify: whi	ite
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and	be fill	Be	17. Father's Name (First, Middle, Richard Pla								e (First, Middle, M nee Scho		·	
Maryland 21215-0036	hould id Me mark matic	ဂ္	19a. Informant's Name/Relations			10b Maili	na Addrose	(Street			al Route Number,		0	a Cada)
Na	nd 2 suith ar		Lesley Plaine			I	_				imore, l		1224	o code)
ē,	iges 1 and 2 should be filed within 72 hours after dea nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items or other traumatic event, It e Medical Examination		20a. Method of Disposition		20b. P	L lace of Dispo emetery, crei	sition (Nan	ne of			Date 2	20c. Locat	ion - City or To	own, State
ê	Page: nt: If ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 💆 Other (5	3 □ Removal from State	3 I	етнесегу, стег	natory or o	mer piac	ce)					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Sign   ur   Transparal Service		ector	. 52	2. Name an	d Addre	ess of Facilit	hard	655 W.	Ralt:	imore 9	Street
8	8 9 E 8	) ())	/m//	Model			altimo		_	$\frac{3120}{2120}$		Dare.	Imore i	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death											Approximate Interval Between
الله الله	Physician		Immediate Cause (Final disease or condition	Cong	esti	VP-	Hec	ret	F	ail	116		1	Onset and Death
-	/Medical Examiner		resulting in death)	Due to (of	s a consequ	ence of):			-					
	Laminor	<u></u>	Sequentially list conditions,	b. Tue to for a		OSID Y	υ							
	nsit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		thn	,								
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Box	leath certifica attending ph I for use as th	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			☐ Ectopic p	regnand	CV			23d	. Date of deliv	1
0.	ne des the a	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant g ☐ Unknown		eath 5	Other (sp	necify)					Month	Day Year
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of Vital Records,	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	d by				<i>3</i>	, , , , ,	g				s 2 🗆 N		
COL	v required	lete									24a. Was ai	, 2	Ah Were auto	opsy findings available
Re	he law e has ige 2 s	Completed									autops perforn	y	prior to co	ompletion of cause of
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>	ysicia s cer direct	o Be	examiner? 1 Yes 2 No	 Hospital: 1 ☐ Inpat	tient 2	ER/Outpatie	nt 3□DC	Oth	0.51		me 5 ☐ Reside	-	Other (Speci	(6/)
סר	Attending Physician: or death. ector: After this certification in the funeral director. It	١	27. Manner of Death	28a. Date of In	jury	28b. Time o Injury		8c. Injur Wor			28d. Describe ho			197
io	endir sath. or: Af he fui	atic	Natural 5 Pendir investi	gation	ay, rear)	,,	М		Yes 2 □ I	No				
Division	or Attu after de Directo in by ti	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined   28e. Place of it	njury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory	, office			28f. Location (St. City or Town		lumber or Rur	al Route Number,
	urs af		and the second						_	- 0				1,
	Hosp 24 ho Fune Fune	edical	29a. Certifier Certifyin (Check only one)	ng Physician: To the bes Examiner: On the basis and manner s	of examinat	wledge, deat tion and/or ir	h occurred vestigation	at the ti , in my o	me, date ar opinion, dea	nd place, ith occur	and due to the c red at the time, d	ause(s) ar ate and pla	nd manner as ace, and due t	stated. to the cause(s)
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Mec	29b. Signature and the of Pertific		nateu.		290	. Licens	se number		2	gd. Date s	igned (Month,	Day, Year)
	- s - 0		) XX				Q.	TC	000	7			wer (	
		-	30. Name and address of person	who completed cause of	death (Item	23a) (Type.		~ ) -	- 000			UCI	·	0,
					494	O EM	TEL	V 4	CENUE	- 61	7LTIMO12	E m	b 212	24
	Sta	te	31. Date filed (Month, Day, Year)	2000 32 Aegis	trar's Signat	ture 1								
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#20b, perFH, G896, 10716/09, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day q Physician/ Reeder arceia 11:50 P M 2009 ctober Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Modical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Hours Honth, Day -58 Director and Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Townsor Location 10d. Inside City Limits **Funeral Director** more 1 Yes 2 No 10e. Street and Numbe Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No 3 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired). (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ Be Father's Name (First, Middle, Last) 18. N ည Calle formant' and Relationship (Typ Mailing Address (Street and Number or Rural Route Number, 50 6 3altimore, 20b. Place of Disposition (Name of centrally, organization or other in 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Signatury of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final Ph sician/ sease or condition resulting in death) Myocardia nour Medical Due o (or as a consequence of) Examiner certalemic 12 hours Sequentially list conditions, Examine of any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury to (or as a consequence of has been signed by the attending physician and e 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed rema MOVUC that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificate 2 🗌 No 1 Yes Yes director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1-Natural 5 Pending work? 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 200 es october, 10,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Bultimore, MD Zizzy 4940 Ea Elizabeth te Iton M.D. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** inson 5:10 AM 10 200 Vina /Medical 4c. County of Death Facility Name (If not igstitution, give and number) 4b. City, Town, or Location of Death Examiner SAIT- MORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace County) **Funeral** 1 ☐ M 2 ☐ F, Months Days 24-013 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepartment of Health and Mertal Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Extrametricinal Legislation and 1 Yes 2 No Director 10g, Citizen of What Country? 10e. Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Sanchary (0-12) College (1-4or 5+) Be ( ည de Clariffe 19b. Mailing 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21, Signature f Funeral Service Lice Pay 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus Cinal disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: for use a If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □Yes 2 XNo Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Wasan has autopsy performed? Yes 2 171No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

P.O. Box 68760, Division of Vital Records,

Saltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

To the I

After this certificate in 24 hours and the Funeral Director: After Miled in by the fundately filled State

Medical

HYSICIAN

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMURE 57.

6 ☐ Could not be

P. SANDHU, MD

DHMH 17 Rev 1/2001

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death **Physician** Month Bay 21501 /Medical ty, Jown, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Davs Hours 76-8 Yrs **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits or Location "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at i♥Yes 2□No by Funeral Director 10f. Zip Code and Number 10g. Citizen of What G 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 2 No 1 □ Yes Specify. 3 Widowed Year or Dates: Be Completed 16a. Decedent's Usual Occupation Properties of work done during most of working life. DO NOT use retired only highest grade completed) marked other than College (1-4or 5+) onstruction 17. Fat/fer's Name (First. Middle. rts Name ∡First, Middle, Maiden Su 2 should be finance and Mental F 2 Department of Health an Important; If item 27 is Pages 1 and 2 usel Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 10/20/200 5 Other (Specify) Signature of sease, or complications that caused in Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest , or heart Immed te Cause ( disease or condition Physician ting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter U denying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): use as the burial-Box 68760, physician The law requires that the death certificate be Physician/Medical the attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an this certificate has autopsy perform 2 No 1 □ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director; 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. within 29b. Signature and the of celtifie 29c. License number 29d. Date signed (Month, Day, Year) 5624 completed cause of death (Item 23a) (Type, Print) and address of person who F. Hanover St 3001 5. JOHN 31. Date filed (Month, Day, Year) 0CT 1 6 2009 State Registrar

DHMH 17 Rev 1/2001

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	1 - State of Maryland / Department of Health Certificate of Death	h B	Reg. No. 1000						
ician	1. Decedent's Name (First, Middle, Last)  August William Rosenberger, Jr.	2. Date of Dea Month 10-13-							
dical niner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		4c. County of Death						
	Rock Spring Village Forest Hill  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Un	der 24 Hrs.   8. Date of Birth	Harford  9. Birthplace (State or Foreign						
l r	212-14-8326 1™ 2□ F 89 Yrs. Months Days Hours		y, Year) Country)						
	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		10d. Inside City Limits						
cto	MD Harford Bel Air		1 □ Yes A∏ No						
Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?						
<b>Funeral Director</b>	1303 Allenby Ct         21014           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent of Hispanic.	Origin? (Specify Yes or No-	USA 14. Race - American Indian,						
by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 □ Married  13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic If Yes,		Black, White, etc.  Specify: White						
Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m	nost of working	16b. Kind of Business/Industry						
du	Elementary/Secondary (0-12) College (1-4or 5+)  12 College (1-4or 5+)  Estimator		Community Employees						
Be Co		other's Name (First, Middle,	Corp. of Engineers  Maiden Surname)						
P P	August W. Rosenberger Sr Gra	ace McCulloug	h						
ľ	19a. Informant's Name/Belationship (Type. Print) Sandra Addington (Daughter)  19b. Mailing Address (Street and Number 1303 Allenby Ct								
		Bel Air, MD	21014 20c. Location - City or Town, State						
	1X Burial 2 Cremation 3 D Removal from State	10-20-2009	Parkville, MD						
	21. Signature of Funeral Service Libensee  22. Name and Address of Fac  Inc 610 W. Mac	cility Schimunek	Funeral Home of BelAir						
	23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.		*						
ledical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year						
þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	bacco use contribute to the cause of death? es 2℃No 3□ Probably 4□ Unknown							
Completed	Hyperlipidemia, Allergez Rhinitis.	24a. Was a							
Be C	25. Was case referred to medical examiner?	1 ☐ Yes ace of Death (Check only of							
은	1 ☐ Yes 2 ☑ No		dence 6 SOther (Specify) Assistations						
Certification:	27. Manner of Death  1	□No	now injury occurred  Street and Number or Rural Route Number, vn, State)						
edical Cer	29a. Certifier  (Check only (Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, or control of the basis of examination and/or investigation, in my opinion, or control of the basis of examination and/or investigation, in my opinion, or control of the basis of examination and/or investigation, in my opinion, or control of the basis of examination and/or investigation.								
Med	29b. Signature and title of certifier  29c. License number  29c. December 29c. License number	er 87	29d. Date signed (Month, Day, Year)						
Medical Certificatio	29b. Signature and title of certifier  29c. License number  29c. License	87							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year PM 13, 2009 Terry Ralph Ramsey de tober 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ceci Maryland al Security Number Health C If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 24, 1942 9. Birthplace (State or Foreign Country) Baltinore, MD. 7. Age Days Hours 11 M 2□ F 212-40-3091 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 ₺ No Bel Air Maryland Harford County 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code United States 151 Drexel Drive 21014 12. Was Decedent Ever in U.S. Armed Forces? 1≦Yes 2□No If Yes, Give Year or Dates: Vietnain 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2Ã No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Ramsey Henrietta Lotz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) Mrs. Mary Ellen Ramsey (nee Rowe 151 Drexel Drive Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel 20c. Location - City or Town, State Date 20a. Method of Disposition 17, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 2009 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. A. 2325 York Road Timonium, Maryland 21093 21. Signature of Fymeral Service License 23a. Par 1. Int if the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she'd or than fail if e. List only one cause of each line. Immediate Cause (Hnall disease or condition resulting in death) a. Squameus CII Carcinoma of the L Approximate Interval Between Onset and Death 2 years Due (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Causa (Disease of Inju that initiated events resulting in death) Last Due to (or as a consequence of): yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Pulmonan 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident

Examiner Hospital or Attending Physician: The law requires that the death certificate be execute and Division of Vital Records, P.O. Box 68760, attending physician ned by the a detached f

certificate after death

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

**Funeral** 

Director

ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examiner must be notified at

death with the Maryland

filed within and Mental Hygiene. Is marked other than

pe t

permit. Pages 1 and Department of Heal

**Physician** 

/Medical

Maryland

Baltimore,

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KE

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

\*29a, Certifier (Check only one)

3 Sulcide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

29d. Date signed (Month, Day, Year) 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VA Mary land 32. Registrar's Signature HEAlth Care System, Perry Yoint, MD 21902 HEUSER 128K 31. Date filed (Month, Day, Year)

State Registrar

filled in by

completely

To the Hospital or within 24 hours at To the Funeral D



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** 2009 302 /Medical 4c. County of Death 4a. Facility Name (If not institution, give stre City, Town, or Location of Death Examiner Himore or town dal tate or Foreign 5. Social Security Number Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace Country) **Funeral** 1 □XM 2 □ F Min. Director 212-82-4536 69 05-07-40 MI) Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show ral", or items 23a or 28a-f show Examinar rest be rectified at 1 XYes 2 □ No Director MD RANDALLSTOWN BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 5116 OLD COURT ROAD Funeral USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No ģ Specify: Specify: BLACK 3 Widowed 4 Divorced 'natural", Completed is ⊓arked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **NEVER WORKED** NEVER WORKED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental ပ DEATLEY RIDGELY MARY WHEELER BROOKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau MARLENE HALL/CAREGIVER 4814 SETON DRIVE, BALTO., MD 21215 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/16/09 BALTIMORE, MD METRO CREMATORY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses JAMES A. MORTON & SONS F.H, INC 1701 LAURENS ST., BALTO., MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burialphysician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) signed by the a 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown has been si e 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate ha 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Iniury 2 🗆 No 1 ☐ Yes 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examina: On the basis of examination and/or investigation, in my opinion, death occurred at the time. date and place. and due to the c 29a. Certifier Medical

the Hospital within 24 hours a

> State Registra

DHMH 17 Rev 1/2001

(Check 29b. Signat

30. Name and add

e and title of certif

ress of

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryianu	•	rtificate of		мена пу	Reg. No.	0.09	33209
	Physicia	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De		Year	3. Time of Death
1	/Medic		Rose E.	Ricker	rt				Octobe		2009	12:10 AM
	Examin	er	4a. Facility Name (If not institution, give Genesis Eldercare		4b. City, Town, or Location of Death Brooklyn Park 4c. County of Death Anne Arundel							
	Funeral		Social Security Number 6. 8	Sex 7. Age	e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs Hours Min.	8. Date of Bir	rth	9. Birthp	place (State or Foreign
	Director		215-14-7579	□ M 2 <b>Ç</b> F	87	Yrs.	Months Days	Hours Will.	May 1	192	2	MD
	land ow		Usual Residence of Decedent  10a, State 10b. County		10c. City,	Town or Lo	cation	-	_		1	0d. Inside City Limits
	a-fsh	Director	Maryland Anne	Arundel				Pasaden	.a			1 □Yes 2 ☑ No
	or 28		10e. Street and Number				10f. Zip Code			10g. Citize	n of What Coun	ntry?
	s 23a	eral	1901 Arundel Roa			140.1	<u> </u>	21122			USA	
36	be filed within 72 hours after death with the Maryland the Hygiene.  Id eithy giene.  Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, I're Madreal Evening the notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent In Armed Forces? 1 ☐ Yes 2 ☑ No Hear or Dates:			Vas Decedent of I fYes, specify Cub I □Yes 2√ No	an, Mexican, Puer  Specify:	to Rican, etc.)		Race - Americ Black, White, e pecify: W	
215-0036	2 hou	ted	15. Decedent's E	ducation		16a. Deced	lent's Usual Occup	pation	ul du u	16b. Kind	of Business/Inc	dustry
21	ithin 7 ne. nan "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	kind of work done OO NOT use retire	d) _	rking			
121	filed within Hygiene. other than " ent, Ire Ma		1.2 17. Father's Name (First, Middle, Last	)		Swit	chboard		me (First, Middle		Teleph	one
au	should be f nd Mental I marked ol ımatic eve	To Be	Elmer Hagne					Rose	•	ahan	mame)	
Maryland	should and Mer is marke aumatic	-	19a. Informant's Name/Relationship	Type. Print)		19b. Mailin	g Address (Street	and Number or R	ural Route Numb	er, City or T	own, State, Zip	Code)
	1 and 2 Health a em 27 is ether tra		Vicki J. Rossbac	h (daught			Arundel					
Baltimore,	S 7 = 0		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special				sition (Name of natory or other pla matory I	- 1	Date 2009		ition-City or To imore, I	wn, State Maryland
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	Issee Hall	A-	A) 22	. Name and Address	ss of Facility S untain Ro				me, P.A. 122
	Physician	0. 4	23a. Part . Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	the death.)	_ r	er the mode of dyi					Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as								
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	uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	ince or):	ead I	Accia	dont	•		
Ö,	rtificate be executed ng physician and as the burial-transit	Еха	resulting in death) Last	Due to (or as	a conseque	ence of):	<u>accions</u>					
68760,	cate b physic the bu	edical		d								
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						230	d. Date of delive	erv
F.O. BOX	t the death ce by the attendi ached for use	Physician/	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnand Other (specify) _	y			Month	Day Year
rds, r	e law requires that the de has been signed by the e 2 should be detached	þ	Part II. Other significant conditions of	contributing to death bu	ut not result	ing in the ur	nderlying cause giv	en in Part I.		tobacco use Yes 2 🔀		ne cause of death?
Hecord	The law recate has bee page 2 shot	Completed							24a. Was	an psy prmed?	24b. Were auto prior to con death?	psy findings available mpletion of cause of
		Φ	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only	2XNo	1 □Yes	2 No
O	Physician; this certific ral director, I	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatien	t 3 DOA Oth	or:	dome 5 ☐ Res		☐Other (Specif	· · · · · · · · · · · · · · · · · · ·
	Attending Plant death. ector: After the by the funeral		27. Manner of Death  ↑ Natural  2 Accident  5 Pending investigatio	28a. Date of Inju (Month, Day	ry v, Year)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe	how injury o	occurred	
DIVIS	al or Affe s after de il Directo ed in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At hom c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location ( City or To	8f. Location (Street and Number or Rural Route Number, City or Town, State)		
	to the hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)  Certifying Pl 2 Medical Example	nysician: To the best of niner: On the basis of and manner sta	f examination	ledge, death on and/or in	occurred at the tivestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) a date and pl	nd manner as s lace, and due to	stated. the cause(s)
)	To the Comp.	Me	29b. Signature and tile of certifier		^	IN	29c. Licens		(		signed (Month,	
			30. Name and address of person who	completed cause of d	eath (Itom 5	(3a) (Tuno	Drint\	5159	6	vae	oberi	6,2009 MD21061
			K. Ambala	valuar	18	450	akwo	od Re	bad.	alen.	Bunie	mD21061
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 6 2009	82. Registra	ar a oignatu	Joan	Same of the same o					

DHMH 17 Rev 1/2001

Please Type of Print in Black Indelible Ink Fasure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death OUTOREL 405AM 2005 Μ. - 10 Raynor 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE WARTHUGTON MEDICAL CENTER Aruninge | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, YAPTI I 25 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Months 1 □ M 2 ☑ F 71 MD Ĩ938 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 Maryland Avenue 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Mckeuan Ruth Corbin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Gilmore 117 Maryland Avenue, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 14 Meadowridge Cemetery 2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or com lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only o le cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MIE disease or condition resulting in death) Oue to (or as a consequence of): 122405 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital **Physician** 

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be finent of Health and Mental

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**Physician** 

/Medical Examiner

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercises must be rediffed at

/Medical

Director

Funeral

Completed by

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Examiner

Physician/Medical

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Certification: To

Medical

29b. Signature and title of certifier

MARATO 31. Date filed (Month, Day Year)

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State Registrar

DHMH 17 Rev 1/2001

32 Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Charles.

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drive Glen Burnue mid 20161

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 103PM 2009 Regina Roden Jovce 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sanare dale Se imane 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 🛣 F 69 214-38-5680 Marvland October 0 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Marvland Baltimore Baltimore County 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 3905 Darleigh Road, Unit D U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Dorothy Fisher Robert Vincent Sebour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Darleigh Rd., Unit D, Baltimore, MD 21236 Clifton Melvin Roden/Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 Removal from State Hillton Service Corp. 10/15/2009 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Lause (Disease or Injury that initiated events resulting in death) Last Monary to (or as a consequençe of IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Live birth 2 | Fetal death 3 Ectopic pregnancy Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ∐ Yes 2 🛱 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once.

**Physician** 

Examiner

**Funeral** 

Director

filed within 72 hours after death with the Maryland

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コのりCe インロの Baltimore, Maryland 21215-0036

Health and Mental Hygiene.

Em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Madical Examinar must be notified at

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Examiner requires that the death certificate be executed burial-trar Physician/Medical

attending physician for use as the buria signed by the a been has After this certificate director, funeral c

ģ Completed Be Certification: To

Division of Vital Records, or Attending death. within 24 hours after deatl To the Funeral Director: Hospital

P.O. Box 68760,

filled in by the

1 Yes 2 No

5 Pending

6

investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one

4 Homicide

State Registrar

Medical

29b. Sign

29c. License number

28c. Injury at Work?

1 □Yes 2 □No

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Name and address of person cause of death (Item 23a) (Type,

000 31. Date filed (Month, Day, Year) 32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day, Year)

2 X ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death nt's Name (First, Middle, Last) Wonth # **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (It not institution, give street and number) Examiner olum Hom Drien If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Country 1 □ M 2 F 86 196-14-5439 Pennsylvania April 19. 1923 Director Usual Residence of Decedent Pages 1 and 2 should be fileophithin 72 hours after death with the Maryland nent of Heath and Mental Hyglene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Morthal Examiner must be notified at Glen Burnie 1 ☐ Yes 2 No Anne Arundel Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21061 454 Longtowne Court Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 Noivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Clerk Giant Foods 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shope John D. Musser Alma F. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11995 Glen Circle, Bridgeville, Delaware 19933 Delores Rhoades-Elswick (Daughter) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park Oct. 16, 2009 Glen Burnie, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funday Pervice Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Par Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Importate Cause (Final disase or condition Physician 96 dif ase or condition resulting in death) /Medical (or as a consequence of) Examiner onai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran and Due to (or as a consequence of): Records, P.O. Box 68760, physician Completed by Physician/Medical the as attending IF FEMALE: use 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year for 5 ☐ Other (specify) ned by the a ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has page 2 performe 2 No certificate 1□ Yes 2 No Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after To the Funeral D completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1015 PM HERBERT R. PATCLIFF 13 10 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTI MORE
If Under 1 Year | If Under 24 Hrs. UNIVERSITY OF MARYLAND MEDICAL CENTER 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) July 27, 1944 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days West Virginia Hours 1 M M 2□ F 216-42-0306 65 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Exerciner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö U.S.A. 21122 1 Dunlap Court items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 'natural", or White ģ Yes. Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Seagrams Company n 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Gertrude Hinchman Ray Howard Ratcliff ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30 Penn National Court, Forest Hill, Maryland 21050 Harbert L. Ratcliff 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 10-19-09 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licenses 3204 Mountain Road, Pasadena, Maryland 21122 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. nmediate Cause (Final weeks **Physician** disease or condition resulting in death) Preumonia /Medical Due to (or as a consequence of): Examiner 3 weeks Seasis Sequentially list conditions, if any, leading to immediate cause. Enter Uniform Grant Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-trai Box 68760, Due to (or as a consequence of): physician Physician/Medical the I use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a P.0. 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 2 No 3 Probably 4 Unknown cardiomyopathy, coronary 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ⚠No 24a. Was an diabetes; hypertension, obstructive autopsy performed? Yes 2.200 page 2 s 25. Was ca e referred to medical examiner? certificate 1 ☐Yes al or Attending Physician: safter death.
I Director: After this certification by the funeral director, p Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1.XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide completely filled in within 24 hours a To the Funeral D To the Hospital Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

Green Street ALICE WONG 31. Date filed (Month, Day, Year, OCT 16

Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South

29b. Signature and title of certifier

29c. License number

Baltimore

1356576102

MD

21201

29d. Date signed (Month, Day, Year)

09-07841 Andre Smith

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

andre Smith	1	State of Maryland / Department of Hea -For State Certificate of Dea			20	10 2221
Physician	R	Registrar  1. Decedent's Name (First, Middle,Last)	111	2. Date of Death		3. Time of Death
Medical Examine		Andre Tucker Smi	th	October 9,	Day Year 2009	0915 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City,	Town, or Location of	Death	4c. County of Deat	th
	ą.		more	Odular IO Data of Breth	(MM/DD/YYYY) 9. Bi	irthplace (State or
Funeral Director		Man	der 1 Year If Under ths Days Hours	Min. O2/03	Fore	ian
Director	_	Usual Residence of Decedent		02/03	11960	Country) MARY (AND
any	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
und show	5 1	MARYLAND NA BALTI.	MORE			1 Yes 2 No
the Maryland a or 28a-f show tifted at once.	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓		ip Code		g. Citizen of What Co	
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hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.		1 Never Married 2 Married Armed Forces? If Yes, spec	dent of Hispanic Origii cify Cuban, <mark>Mexican,</mark> F	n? ( Specify Yes or No- Puerto Rican, etc.)	White, etc.	erican Indian, Black,
		1 Yes 2 No	2 No specify:		Specify: R	IACK
ours aft	3 -	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usua diving most of the	al Occupation (Give ki orking life. DO NOT u		16b. Kind of Business	s/Industry
2 3 II t		Elementary/Secondary (0-12) College (1-4 or 5+)			STOUTOG	D PARKING
5-0036 ed within 72 hour lygiene. other than "natur the Medical Exam	ξŀ	17. Father's Name (First, Middle, Last)	18 Mother's	S Name (First, Middle, M	aiden Surname)	Difficults
215-0036 be filed within ma Hygiene. Red other tha ent, the Medic						KER
D 21214 should be fill and Mental F 7 is marked natic event, 1	2	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Addre	ss (Street and Numb	ber or Rural Route Numb	ber, City or Town, Sta	ite, Zip Code)
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Ro Completed by	4	ERNEST SMITH (FATHER) 301 Ma 20a. Method of Disposition (N	MECHEN	St., APT.	200 Lacation - City	0., MD 2/2/7
ore, Mes I and 2 of Health If item 2		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	e)	<b>15</b> /	200, Location - Oity	a Dag bad
time t. Pag tment tment rfant: y or ot		1 Denotion 5 Other Specific	M ("LOMATORY L	10 <del>1761</del> 2009	BAHMORE	, MARYIMIO
Baltimo permit. Page. Department o Important: injury or oth		21 Signature of Funeral Service Licensee 22. Name ar	OH H. BR	DUN TR.	FUNERH	MD 21217
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod	e of dying, such as ca	ardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease a.Fatty Liver				Death
xammer	1	or condition resulting in death)  Due to (or as a consequence of):				
i d	5	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
red (4)		cause. Enter Underlying Cause (Disease or injury that hittested  Company (Company) least  Due to (or as a consequence of):				
Busit and A	Ĭ	d				
Isopital or Attending Physician: The law requires that the death certificate be executed thours after death.  Howeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transitional filed in by the funeral director, page 2 should be detached for use as the burial - transitional filed in the funeral director, page 2 should be detached for use as the burial - transitional filed in the funeral director.	3 -	X AMENDED 23a,27,perME, g8 #20b,perFH,G896,10	97 11/6/09	9 TT		
zate be	₹ .	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	· ·
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Box e death c	2	1 Yes 2 No 9 Unknown 9 Unknown	recity)			3
that the detached	Z C	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Par			to the cause of death?
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of Vital Records, ng Physician: The law requir Nfler this certificate has been s meral director, page 2 should	Completed			24a. Was a autop: perfor	sy prior t	to completion of cause of
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ician: The ician: The secrificate rector, page	e O	25. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/Outpatient 3	26.Place of Death (		Residence 6 ✔ Ot	her Scene
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To the Hospital or A within 24 hours after To the Funeral Dire completely filled in broad and a second to the funeral Confifer or the funeral Confifer or the funeral Confifer or the funeral Confifer or the funeral Confifer		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at one)  2 Medical Examiner: On the basis of examination and/or investigation, in	he time, date and pla	ace, and due to the caus	e(s) and manner as s and place, and due to	stated. o the cause(s)
To the IIc within 24 To the Fu completel	l led	and manner stated.	29c. License number	,	29d. Date signed (i	
	-	Marie M. Marie	O.C.M.E.		October 10, 20	
	-	30. Name and address of person who completed cause of death (Item 23a)				****
		Margarita Korell MD. Assistant Medical Examiner 111 Penn S	Street, Baltimore	e, MD 21201		
Stat Registra		31. Date filed (Month, Day, Year)  OCT 1 6 2009  32. Registrar's Signature	2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 30 **Physician** 2000 Marcelean Swinehart 10 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 09-17-1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Min. 1 M 2X F Maryland 81 217-24-7648 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2X ☐ No Director Harford MD Fallston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 326 Old Joppa Rd 21047 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Reserve Bank Proofer 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Oscar Winkler Mary Anna Williams other traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If Iem 27 is
any Injury or other trau
once. Dottie Demers (Daughter) 5427 Broadway WhiteHall, MD 21161 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 10-16-2009 Baltimore, MD 21. Sign ture of Funeral Service Sicensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir mun D. Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5 yeas **Physician** macstile /Medical Due to (or as \*\* onsequence of) **Examiner** 4eas Coronary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Donatient 2 ER/Outpatient 3 DOA Medical Certification: To he Hospital or Attending Physin 24 hours after death.
he Funeral Director: After this pletely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Xcertifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

whether Marcelson M80033 Division of Vital Records, P.O. Box 68760 Attending within 24 hou

To the Fune

completely fil the 0

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500

29c. License number

H0067817

hesapeake Dr. Bel Air, MD 21014

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10-08-2009 0800 A M Autumn Grace Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Fallston Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F ΜĎ Ø Director 10-08-2009 n/a Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Harford Fallston Director MD 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 21047 USA 487 Copeland Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ White 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) n/a 12 should be filed w. h and Mental Hygier 7 is marked other th n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emily Smith Dave Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Smith (Mother) 487 Copeland Rd Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10-12-2009 Bayview Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 80 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee to face Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** xtreme disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): mith, Baby Gid M80051653 Due to (or as a consequence of) ed by the attending physician detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes\_ 2 ER/Outpatient 3 DOA Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar SISQUEHPANNA OB GYN, 520 UPPER CHESAPSAKE DEINE, BELANE, HD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASMINE N. LAMPADALIOS

1 6 2009

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:05 PM 11# 2009 SMith ockber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Medical Arrundel Anne alen BULLER If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Jan 18 1 Social Security Number b. Sex **Funeral** 1 ☐ M 2 🔀 F 217-16-3370 85 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Mudical Examination must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 및 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7788 East Shore Road 21122 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public Schools 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) William Eisedhood Gordon Lillian ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Smith (spouse) 7788 East Shore Road, Pasadena, MD 21122 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 of Euneral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part . Enter the n wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part I. Enter the dease, or como Immediate Cause (Final **Physician** PNU ancer disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Tause (Usease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 10 Natural 5 ☐ Pending neral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 11th D0068976 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Beyene Washington

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

16 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DOMOBER 2009 08:05AM Michael Simko /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Months Days 236-18-6688 Director 88 1920 4, West Virginia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov Directo 1 ☐ Yes 2 No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examinest install once. 134 Warwick Drive 21093 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Xes 2 □ No If Yes, Give Year or Dates:WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) <u>Teacher</u> Public Schools Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဥ Simko George Marv Dorich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Elizabeth Simko</u> Wife 134 Warwick Drive Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-16-2009 Towson 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ESOPHAGEAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting to the cause) Exami The law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE STAGE icate has been sig , page 2 should b 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2 No 1 🗆 Yes fo the Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28h Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide in 24 hour. the Funeral Directory filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POH L.IM. M. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

- Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day THOMAS 9:45 PM ,2009 ctober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FALLS ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-26-9827 1 □ M 2 🗷 F Months Days Hours Min Director MARYLAND MARCH 17,1931 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Evaruings must be notified at Directo MARYLAND 1 MYes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3319 21215 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 [X]
If Yes, Give
Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 XNo Specify: 2 Specify: BLACK 3 Widowed 4 Divorced "natural", er than "natura", the Modical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) YEARS HOUSEWIFE OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic even AUBURN CRAHAM ၉ MAE EDITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Bepartment of Health Important: If item 27 any injury or other transme. BERNARD DAVID THOMAS (4USBAN) 3319 BELLE AVE, BALTIMORE, MID 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)

505EPH H. CROLLUL TR.
FUNERAL HUME and CREMATOR 10/14/2009 BALTIMORE, MARYLAND 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
SOSEPH H. BRULON SR. FUNERAL HUME
2140 N. FULTON AVE., BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee Mulliamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2418IMERS disease or condition resulting in death) DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Eiter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy this certificate of Vital 1 ☐ Yes 2 ☐ No 1 □ Yes 2**X**(No Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Surviving Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division To the Hospital or Attending Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No reral Director: / 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated within 2 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) MID DU059107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 DRIVE REISTERSTOWN Uma MANESS CENTER State Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Brandon Lever Tu	1	For State Certificate of Death	Hygiene Reg.	No. 2000 3320
Physician Medical Examin	n/	Drancton / P. Car / Urner	Date of Death     Month	3. Time of Death
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De	October 9, 2	4c. County of Death
Funeral	Ħ,	25 Washington Road Westminster  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24	Hrs. 8 Date of Birth/	Carroll  MM/DD/YYYY) 9. Birthplace (State or
Director	c		vin. April.	5 984 Foreign MAry Land
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of Location ,		10d. Inside City Limits
<b>*</b>	-1	Ma BAHimore Pikesville		1 Yes 2 No
and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.  Them 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 21208	10g	Citizen of What Country?
death with th or items 23a must be noti	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? 14. Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue		14, Race - American Indian, Black, White, etc.
after de	ᇍ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes, Sive Year 1 Yes, 2 No specify:		Specify: LIACK
2 hours aff "natural"		15. Decedent's Education (Specify only highest grade completed)  Elementary (Segradary (0-12) College (1-4 or 5+)  College (1-4 or 5+)		6b. Kind of Business/Industry
5-0036 led within 7 Hygiene. other than	Completed	12th Partender [C	hel	1) estauran
21215-00 Juld be filed with Mental Hygien marked other c event, the Me	8	17. Father's Name (First, Middle, Last).  18. Mother's Na  On	orne First, Middle, Ma	den Surname)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	^[	19a, Informant's Name/Relationship (Type, Print)  Once Jumer Mother 19b. Majling Address (Street and Number)  1515 Slade Ho	or Rural Route Number	er, City or Town, State, Zip Code)
more, ME Pages I and 2 s' nent of Health an ant: If item 27		20a Method of Disposition  20b Place of Disposition (Name of cemetery, crematory or other place)	0 Pate 15/04	20c. Location - City or Town, State
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr	+	4 Donation 5 Other Specify: 2 . Sign t re of Funeral Service Jicensee 22. Name and Address of Facility	Tocoph H.	Brown & Ellen
1.1	1	2. Part I. Enter the disease, or complications that caused the diath. Do not enter the mode of dying, such as cardia	n All B	AI+O, Ma- , shock, ir heart Approximate Interval
Physician /Medical	- 1/	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries	ic or respiratory arres	Between Onset and Death
⁻xaminer	4	Of condition resulting in death)  Due to (or as a consequence of):		
	luer	Sequentially list conditions,  Due to (or as a consequence of):  cause. Enter Underlying Cause		
ed nsit		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·	
0, t. be executed	edical	UNPENDED AMENDED		
8760 lificate b	الخ	F FEMALE:  23c. If yes, outcome of pregnancy  3b. Was decedent pregnant in the  1 Live birth  2 Fetal death  3 Ectopic pre	gnancy	23d. Date of delivery  Month Day Year
that the death certificate that by the attending phy detached for use as the t	Sic	past 12 months?  1 Yes 2 No 9 Unknown  4 Pregnant at time of death 5 Other (Specify)  9 Unknown	,	,
O. B. nat the d at the d ctached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
cords, P.O. Iaw requires that that been signed be 2 should be detae	tea by		1 Yes	
SCOFC ie law re te has be ge 2 sho	Completed		autopsy perform	prior to completion of cause of death?
of Vital Recing Physician: The I After this certificate Uneral director, page	De L	25. Was case referred to medical examiner? 26. Place of Death (Che examiner)		No 1 Yes 2 No
n of Vit ding Physic a. After this of	٥,	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nu  27. Manner of Death  28a. Date of Injury  28b. Time of Injury 28c. Injury at Work?	rsing Home 5 Re	esidence 6 🗸 Other: Scene
Sion C Attending death. ctor: Af	ation	1 Natural 5 Pending Jan 8, 2009 Pending 2 ✓ Accident Investigation Investigation	Subject pinne	
Division of Vital Records, ta or Attending Physician: The law require rs after death.  al Director: After this certificate has been signed by the funeral director, page 2 should be the fineral director.		3 Suicide 6 Could not be determined (Specific) Parking Lea	or Town, Star	eet and Number or Rural Route Number, City te) Road, Westminster, MD
hou pi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(	s) and manner as stated.
To the within 2 To the complet		one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
		Theodore My Hora Tr., m. ) O.C.M.E.	DOME	October 9, 2009
	1	Name and address of person who completed seals of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltim	ore, MD 21201	
Sta	e 3	B1. Date filed (Month, Day, Year)  OCT 16 2009  32. Segistrar's Signature  OCT 16 2009		
Registra	I	101 10 FARE DE 14		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HELEN L. VLACH OCTOBER 2009 7:53 P.N 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8007 DALESFORD ROAD PARKVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F 198-20-6546 83 3/11/1926 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE PARKVILLE 1 ☐ Yes 2 ☐XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7912 DALESFORD ROAD 21234 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3K Widowed 4 □ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry SOCIAL SECURITY (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) KEY PUNCH OPERATOR 12TH GRADE ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALEXANDER LUCAS JULIA LUCAS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDY BARKER/DAUGHTER 8007 DALESFORD ROAD PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MORELAND MEMORIAL PK 4 ☐ Donation 5 ☐ Other (Specify) 10/19/2009 HILLENDALE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility MO1139 THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD at 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tow hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Items 23a

'natural", or

than

if Health and Mental if

permit. Pages 1
Department of F
Important: If ite
any injury or ot

other traumatic

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

þ

Completed

Be

0

/Medical

requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the a

this

the Hospital or Attending I hin 24 hours after death. the Funeral Director; After

within 24 hours a

Examiner

Physician/Medical

2

Completed

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 Unknown

> 1 ☐ Yes 2 🗆 No

DAUGHTER'S RESIDENCE 6 Dother (Specify)

25. Was case referred to medical examiner? Be 1 Yes 2 No 27. Mann f Death 1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital

1 Inpatient

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

21286

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifie (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TOWSON, MD

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHIN M. TUNG MD State

312 GOUCHER BLVD.

Registra DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:35 PM Marshall Vitullo Oct 12, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Westminster Carroll County General Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Months Days Hours Min. Director NC 413-62-3229 Jan 27, 1936 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Mydical Evantion in usi os notified at 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Howard **Ellicott City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21043 8335-C Montgomery Run Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 

Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **NSA Business Analyst** 12 should be filed with and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall Dunlap George Lockhart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traum 4958 Reedy Brook Lane Columbia, MD 21044 Mitch Vitullo Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 Removal from State Oct 14, 2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) **Atlantic Crematory** 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease shock, or heart failure. e, or complications that caused th List only one cause on each line. Immediate Cause (Final Physician 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. I the 1 ☐ Yes 2 No 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of certificate has page 2 s autopsy performe death? 1 ☐ Yes 2 X No 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 25 No **1**√√ Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural hours after death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 ☐ Homicide To the Hospital 29a. Certifier 🕰 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

29b. Signature and title

31. Date filed (Month, Day, Year)

of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician ins 2009 /Medical 4c. County of Death give street and number) **Examiner** And AMStorum ISAHO If Under 24 Hrs. 9. Birthplace 7. Age (In yrs. last birthday **Funeral** Months 1 □ M 2 KF land Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at timore 1 Yes 2 □ No **Funeral Director** 10g. Citizen of What 10e. Street and 10f. Zip Code 2/0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use refired)

Control of the second 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Mother's Name (First, Middle, Malgien Surname) 18 (First, Middle, Last) CRUK City or Town, State, Zip Code Mailing Address (Street 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) uneral Service Licenses the Approximate Interval Between Onset and Death 23a. Part 1 Inter the di shoot or heart fully ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line Immediate Cause (First) **Physician** Atheroscieratic Cardiovascular di ea e or condition rullting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Dire to (or as a nonsequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Ye a 5 Other (specify) P.O. 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 4 known 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No 1 □Yes 1 □ Yes certific within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 6 (Specify) Other: 4 \sum Nursing Home 1 Yes 2 | Wo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

State Registrar

29b. Signature and title of certifier

MS Kajup anse M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pakse, M.D.

25

Registrar's Signature

D005746S

Main St., Suite 200, Reisterstown, MD, 21136

29d. Date signed (Month, Day, Year)

Lewis Jermichael White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07964 State of Maryland / Department of Health and Mental Hygiene UNK UNK 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month October 14, 2009 0124 hrs Lewis Jeimichael White **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore N/A Universty Hospital 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 3 4 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex **Funeral** Country) Months Days Hours Director 426-13-3497 MS 6/5/75 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ob. Count any MD Baltimore Reisterstown 1 X Yes 2 No 28a-f show , or items 23a or 28a-f show Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12900 Gent Road 21136 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11, Marital Status traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? African hours after death 1 X Never Married 2 Married 2 X No. Yes altimore, MD 21215-0036
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portant: If item 27 is marked other than "naturral", or
iry or other traumatic event. the Madis." Yes 2 X No specify: Specify: American Widowed Divorced Yes, Give Year ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Transport Driver 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carolyn White Horace Hartwell Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 12900 Gent Rd, Reisterstown, MD 21136 Carl White/Uncle 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Columbia, MS 1 X Burial 2 Cremation 3 Removal from State 10/22/09 Resthaven Cem. Donation 5 Other Specify. 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Lic 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease :aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical tending physician a use as the burial -AMENDED UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Completed by Yes 2 ✓ No 3 Probably 4 Unknown σ. Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy s certificate has b rector, page 2 sh performed? death? ✔ Yes 2 No 1 🗸 Yes No 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: 1 DOA Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 Yes 28d. Describe how injury occurred After 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot Oct 14, 2009 0044 hrs Natural Yes 2 V No Pending Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 2300 Baker Street , Baltimore, MD To the Funeral D determined (Specify) Local Street 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 14, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

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	Physici	an	Decedent's Name     DECEMBER		•						2. Date of E	Da	y Year	3. Time of Death
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36	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show to Medical Evanting, must be notified at	by Funeral Director	1 Never Married		1 Tyyes If Yes, Giv	2 □ No ve		1 ☐ Yes		Specify:	no riican, etc.)		Black, White, Specify:	91C.
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29	icate be executed physician and the burial-transit			•	d									
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-	in the	Certification:	4 ☐ Homicide	determined	28e. Place	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, st ify)	treet, factory	, office		28f. Location City or To	(Street ar own, State	nd Number or Rura e)	ıl Route Number,
3	Hospital 24 hours a Funeral I		29a. Certifier	Certifying Pl	vsician: To the	hest of my kn	owledne dea	th occurred	at the tin	me date and plac	e and due to th	o caneo/s	s) and manner as s	stated
2	e Hos 124 h e Fun letely	Medical	(Check only 2 one)	☐ Medical Exa	miner: On the ba	asis of examin	ation and/or i	nvestigation	n, in my o	pinion, death occ	urred at the time	e, date an	d place, and due to	the cause(s)
	To the within 2 To the comple	Me	29b. Signature and	e of certifier	1	//	4 . 0	290	c. License	e number		29d. Da	te signed (Month,	Day, Year)
			>/	1	50	1	M	)	100	5726	13	00	toper	13 2000
	MH		30. Name and addres	s of person who	completed cause	e of death (Iter	m 23a) (Type	, Print)			4	7	1000	13,2009
	1		Fermin	Barri	reto,n	7.D.S	0014	oper (	hes	apeak	elr.	Bel_	tic, Mo	21014
	Sta Registra	re.	31. Date filed (Month,	CT 1 6 2	009 32. 9	gistrar's Signa	A	RENE	P				-	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend item 25,27 per doc g896 10-16-09 vt
State of Maryland 7 Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Worthington 2009 Raymond Leroy October 10:08 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days 1**X** M 2□ F Hours 042-12-1061 93 Director 1915 | Connecticut December 2 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
snit: If item 27 Is marked other than "natural", or items 23a or 28a-f shov. rry or other traumatic event, The Nedical Examinating at the motified at 1 ☐ Yes 2 X No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14713 Carrolton Road 20853 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status as Decedo... med Forces? MXYes 2∐No WWII 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White ⋛ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Officer Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry H. Worthington Helen E. Moffatt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trausons. Audrey M. Worthington / Wife 14713 Carrolton Road, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date October 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 16, 2009 Ellicott, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01305 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 Robert A. Pumphrey Funeral Home/Roc 300 West Montgomery Avenue, Rockvil 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Due to (or as a conservence of): 30 minutes disease or condition resulting in death) /Medical Examiner mo omt. Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tracture Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence o P.O. Box 68760, attending physician a for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy 5 D Other (specify) in the past 12 months? Month Day Year signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗷 No 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XX Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Sell zetting 1 ☐ Yes 2 ☑ No Sep 33 3009 UnKM 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 147/3 Carrol Ton RN 4 Homicide HOme OH Rockulle MD 20853 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number October 12, 2009 1)47682 Marin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road, Olney, Mary land, 20832 2901 Olvey - Sand istrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2009 Рм Cynthia Anne Weir 8:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7, Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 M 2 X F Months Hours 47 220-78-7264 Yrs Director 962 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Parkville Maryland Baltimore 1 🗌 Yes 2 🛛 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 21234 8438 Oakleigh Road U.S.A. death v 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Beauty Manicurist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked or any injury or other traumatic eve ၉ John Weir Margaret Prince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Berstein Starke/Friend 123 West Shoreview Drive, San Ramon, CA OCTOBER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Service Corp 10/14/2009 | Towson, Maryland illtop uneral Service Lice see 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions ine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Exami Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CYNTHIA WEIR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe 1 🗌 Yes 2 🗎 No Yes 2 No Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Hospital or Attending P 24 hours after death. Funeral Director: After the 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and # 29d. Date signed (Month, Day, Year) 2009 ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES,

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registras Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1120 PM Marcella Olivia ANDERSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital <u>Washington</u> <u>Hagerstown</u> If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country)
Maryland 1 □ M 2 🏻 F Months Days Hours Min. 85 Director 219-12-1431 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 27 Schoolhouse Court <u> 21713</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 Hygiene. If Yes, Give 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 <u>Hairdresser</u> Beauty Salon Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ George C. Reed Frances Florence Whitmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Morgan - Sister 3812 Chestnut Grove Road, Keedysville, Md. 21756 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery | 10/9/09 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home ames 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) weeks Medical Due to (or as a consequence of) Examiner aule Collas Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed Usmany physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant : 9 Unknown Pregnant at time of death ed by the a detached f signed to Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Ity pertension cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed osteomosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate | Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \sum No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1🗶 Inpatient 2 🗆 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and title of

31. Date filed (Month) Pay Year)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lappans Rd Boonsboo MD 217/3

29c. License number

D44996

29d. Date signed (Month, Day, Year)

October 8, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2000 1:37 pm BESSIE M. ALGER 2 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** BALT IMORE 1960H AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/17/1923 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. VIRGINIA 1 □ M 2 🔀 F 86YRSYrs. 216-68-5945 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shov raumatic event, it at Modical Examinatic event, it at Modical Examinatic event. HOWARD 1 ☐ Yes 2 No MD. ELLICOTT CITY Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10150 OLD FREDERICK RD. 21042 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. WHITE 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 4YRS HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked any injury or other traumatic or other. HENRY ALGER OLLIE SUSAN WOODWARD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DEBORAH LYNN JENKINS(Daughter) 3124 WEST SPRINGS DR. ELLICOTT CITY, MD. 21043. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CREST LAWN 10/02/2009 MARRIOTTSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL 21. Signature of Funeral Service Licensee P.O. BOX 195 SYKESVILLE, MD. 21784. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** lears /Medical Due to (or as a consequence of) Examiner ears tension Sequentially list conditions, if any leading to increase acuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of as a consequence of) certificate be executed Exami sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the l for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown After this certificate has been s funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐No 24a. Was an performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🛂 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director; After t 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

WJL 12

> State Registrar

31. Date filed (Month, Day, Year) SEP 2

900 Zilbermint 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Caton Ave

2009

21229

MD

Battimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Franklin Broadus Certificate of Death 1. For State Registrar 3. Time of Death-2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month October 9, 2009 0749 hrs Medical Examiner William Franklin Broadus, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) St. Mary's Lexington Park 46543 Valley Court g. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** Foreign Months Days Hours Min MD 12/09/1950 Director 58 220-54-2836 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State A II 1 X Yes 2 No items 23a or 28a-f show ust be notified at once. Lexington Park St. Mary's MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 20653 US 46543 Valley Court 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status narked other than "natural", or items event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No Black Specify Yes 2X No specify: Yes, Give Yea Widowed 4 X Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hou riment of Health and Mental Hygiene. riant: If item 27 is marked other than "may pro other traumatic event, the Medical Ext College (1-4 or 5+) Elementary/Secondary (0-12) Restaurant Cook 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Jane Smith William Alexander Somerville, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 368 Snyder Lane, Culpeper, VA 22701 Virginia L. Brooks / Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/15/2009 Hagerstown, Md rtment c rtant: 1 Cedar Lawn Mem Park Other Specify Donation 5 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death Medical Tricyclic antidepressant (amitriptyline) and Immediate Cause (Final disease xaminer Due to (or as a consequence of): alcohol intoxication or condition resulting in death) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit 23a,2/,28a-f,perME, g897 11/4/09 TT Physician/Medical tending physician a use as the burial -X UNPENDED AMENDED the Hospital or Attending Physician: The law requires that the death certificate be earling 24 hour, after death. Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown the ched 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. by 1 Yes 2 No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one 25. Was case referred to medical Be Other: examiner? Residence 6 V Other: Scene Hospital: Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 this No 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a, Date of Injury After 27. Manner of Death Certification: Yes 2X No Natural Director: 5 Pending 10/9/09 Fd 8:45 Fd 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town State + 6543 Valley Court Lexington Park, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide found at residence (Specify) Funera Homicid ij 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) 29b Signature and 29d. Date signed (Month, Day, Year) 29c. License number October 10, 2009 O.C.M.E ·Ca 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (Month 2009

State Registra

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 09/28/09 10:30 p William L. Butler 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St Thomas Moore Medicial Complex Prince George
9. Birthplace (Sta Hyattsville If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, tate or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Months 1 ★ M 2 □ F 01/28/1917 DC 92 578-16-2518 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ▼Yes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number # 802 United States 20001 2301 11th Street NW 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Black 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4or 5+) Private Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vincent H. Butler Aline Haley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara J. Roberts/ Daughter 2312 Romney Court Landover, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln Memorial 5, 2009 Suitland, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee Stewart, III 4001 Benning Rd. NE Washington, DC 20019 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day Respiratory Failure Due to (or as a consequence of): Lung Mass Month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Anemia Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 X No 3 Probably 4 Unknown Osteoporosis Failure to thrive (Copd) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🖺 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

executed

certificate be

Box 68760.

P.O.

Records,

**Physician** 

Examiner

**Funeral** 

**Director** 

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permit. Pages 1 Department of H Important: If ite any Injury or ot

2 should be fill and Mental h

within 72 hours after

Baltimore, Maryland 21215-0036

other traumatic event, the Macteri Expression count

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1 Yes 2 No

and burial-trait attending physician the as asn detached signed by t page 2 should Completed peen Be

certificate has funeral director, After this

Division of Vital Attending Physician: Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation al or Attend s after death il Director: / 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20878 MD 10810 Darnestown Rd. Suite 202 Gaithersburg, Md. Raman Tuli, 32. Registra's Sign State

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Registrar

## Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If we Medical Examinar must be on this at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar DHMH 17 Rev 1/2001

	State of Maryla	•	rtificate of		Reg	No.	111 73	3800
Registrar  1. Decedent's Name (First, Middle, L	ast)				2. Date of Death	~ `~		3. Time of Death
T. D	1 11				Month	Day 28	Year 2009	160 i 1
la. Facility Name (If not institution, g.	elon III		4h City Town o	r Location of Death	1	4c. County	-	1001
1011111	1 1 1			^		1.1	>	
200	vendust Huspital Sex 7. Age (In vi	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthpl	ace (State or Forei
	1 <b>√</b> M 2□ F	Yrs.	Months Days	Hours Min.	(Month, Day, Young) 02/12/19		Count	D.C.
577-74-0094 Usual Residence of Decedent	57			<u> </u>	102/12/19	32	wasii.	, , O.C.
10a. State 10b. County	10c.	City, Town or Lo	cation				10	0d. Inside City Limi
D.C.		Washin	aton					1 √Yes 2 □ N
10e. Street and Number			10f. Zip Code		10g	. Citizen of V	Vhat Count	try?
125 2m3 C+ N1	л			20001		U.S	. 7	
425 2nd St., N. I	12. Was Decedent Ever in	US 13	Was Decedent of h		necify Yes or No-		e - America	an Indian.
	Armed Forces?	0.0.	Was Decedent of half Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)		k, White, e	
1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∏Yes 2 ☐ No If Yes, Give Year or Dates:		1∐Yes 2√∏No	Specify:		Specify	: Bla	ack
		16a Dece	dent's Usual Occur	nation	16	b. Kind of Bu	isingss/Ind	luetry
15. Decedent's I (Specify only highest g	rade completed)	(Give	kind of work done DO NOT use retire	during most of wor				,
Elementary/Secondary (0-12)	College (1-4or 5+)			,	l v	erox C	יחדמי	ration
12th 17. Father's Name (First, Middle, Las	t)	Xero	x Techni		ne (First, Middle, Ma			
James W. Bel	,				Unknown		,	
					<del></del>	No	04-: -	0-4-1
19a. Informant's Name/Relationship					ıral Route Number, C	-		Code)
William David Bo		1			hington,D		20001	
20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3	Removal from State	<ul> <li>Place of Dispo cemetery, crer</li> </ul>	sition (Name of natory or other pla	ce) 10-2	-2009 20	c. Location -	City or To	wn, State
4 □ Donation 5 □ Other (Spec	ify) Ch	esapeak	e Cremat	ory, Inc.		Belt	svill	Le,Md.
21. Signature of Funeral Service Lice	nsee	22	2. Name and Addre	ess of Facility 4	1925 Burro	ughs A	ve.,	v.E.
Jany 1	Grall		H.S.Wa	shington	& Sons Co	.,Inc.	Was	sh.,D.C. 20019 Approximate
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons		Disc.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg  1 ☐ Live birth 2 ☐ Fe	etal death 3 [	☐ Ectopic pregnand	>y			te of delive	ery Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown	uouan - 3 L	_ outer (apoury) _					
Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause civ	en in Part I.	23e. Did toba	cco use cont	tribute to th	e cause of death?
Mussels	-	•				2 □ No	3 ☐ Prob	
Lid bor Ledgerer								. –
Hypertension					24a. Was an autopsy	24b.	Were autor prior to cor	psy findings availal npletion of cause o
Didhetu Malli	dus				performe	d?	death? 1 □ Yes	
25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one)			
	Hospital: 1 ☐ Inpatient 2	R/Outpatier	nt 3 DOA Oth	ner: 4 🗆 Nursing H	fome 5 ☐ Residen	ce 6 □Oth	ner (Specifi	y)
1 ☐ Yes 2 ☐ No	28a. Date of Injury (Month, Day, Year,	28b. Time o			28d. Describe how			
27. Manner of Death	(month, Day, real,	. a ijury		k? ]Yes 2□No				
1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	on		eet, factory, office		28f. Location (Stre. City or Town,	et and Numb State)	er or Rura	I Route Number,
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	be 290 Place of Injury At	home, farm, str ecify)						
27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying F		nowledge, deat	h occurred at the t	me, date and place	e, and due to the cau urred at the time, date	ise(s) and m e and place,	anner as s and due to	tated. the cause(s)
27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  27. Manner of Death 5 Pending investigati 6 Could not determine	28e. Place of Injury - Al building, etc. (Spe	nowledge, deat	h occurred at the t	opinion, death occi	urred at the time, date	ise(s) and me and place,	and due to	the cause(s)
27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Chack only one)  27. Manner of Death 5 Pending investigati 6 Could not determine	28e. Place of Injury - Al building, etc. (Spe	nowledge, deat	h occurred at the tovestigation, in my	opinion, death occi	urred at the time, date	e and place,	and due to	o the cause(s)  Day, Year)
27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Chack only one)  27. Manner of Death 5 Pending investigati 6 Could not determine	28e. Place of Injury - Albuilding, etc. (Specifical)  Physician: To the best of my laminer: On the basis of examand manner stated.	knowledge, deat ination and/or in	h occurred at the tovestigation, in my 29c. Licens	opinion, death occi	urred at the time, date	e and place,	and due to	o the cause(s)  Day, Year)

			For State Registrar	State of Marylar		artment of F			Reg. No.	* 3	Time of Death
	Physici		1. Decedent's Name (First, Middle, Las	t)	Bis	dinger		el/onth		Zog A	16:1884
1	/Medic Examir	er	4a. Facility Name (If not institution, give			4b. City Town, or Baltimore	Location of Death		4c. County	of Death	
	Funeral Director		The Johns Hopkins Hopkins Hopkins Social Security Number         6. S           202-30-0307         1		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Aug 18	h y, Year) 3 1940	9. Birthplace Country)	e (State or Foreign PA
	Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Howard		ity, Town or Lo						Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28a st be notif	al Director	10e. Street and Number 10800 Warfield	Place		10f. Zip-Code 21044			10g. Citizen of W		
036	be filed within 72 hours after death with the Maryland rital Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 【XWidowed 4 ☐ Divorced	1 TV: Yes 2 No	750	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🙀 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - American I k, White, etc.	Indian,
21215-0036	within 72 hou ene. than "natura ne Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4 or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired regiver	during most of work	ing	domest:		try
land z	Q ta 25 9	To Be Co	17. Father's Name (First, Middle, Last) Raymond Beatty				18. Mother's Nam	Smith			
Σ	nd 2 alth a 27 l		19a. Informant's Name/Relationship ( Terri Klatzkin (d	aughter)	6111	Timothy	Ct., Colu	mbia, M			
Baltimore,	Page ent o it: If y or		20a. Method of Disposition  1 Burial 2 Coremation 3 4 Donation 5 Other (Specifications)  21. Signature of Funeral Service Licen	Removal from State A1	cemetery, cre 1 Coun				Sykesv	ille, l	MD
Ba	permit. Pa Departmer Important: any injury once.		▶ Parge Harght	Herbert	. P	.O. Box 1	95 Sykesv	ille, M	ID 21784	ile & Ci	napei
1	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or as a conse	quence of):	ter the mode of dy	ng, such as cardiac	or respiratory a	rrest,	ln	oproximate terval Between nset and Death
8760,	ificate be executed g physician and as the burial-transit	ledical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
Box 6	ath cert	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   yes   No 9   Unknown	23c. If yes, outcome of preg 1	tal death 3	☐ Ectopic pregnan☐ Other (specify) _	cy			te of delivery onth Da	ay Year
rds, P.O	v requires that the de been signed by the s should be detached	ed by Phys	Part II. Other significant conditions	ontributing to death but not r	esulting in the	underlying cause (	given in Part I.	23e. Did	tobacco use con Yes 2 No		cause of death?
Il Records,		Completed						24a. Was auto perfe 1  Yes	psy ormed?	prior to comp death?	y findings available bletion of cause of
of Vital	Physician: The I this certificate ha eral director, page	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 MInpatient 2	☐ ER/Outpatie	ent 3 □ DOA Ot	26. Place of Deather: 4 ☐ Nursing Ho	277	one idence 6 ☐ Oth	ner (Specify)	
	g Phys er this neral di	n: 70	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju		28d. Describe	how injury occur	red	
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury - At			Yes 2 No		(Street and Numi wn, State)	ber or Rural F	Route Number,
	To the Hospital of within 24 hours a To the Funeral D completely filled it	Medical Ce	29a. Certifier 1 Certifying Pl (check only 2 Medical Exa	nysician: To the best of my kr miner: On the basis of examinand manner stated.	nowledge, dea nation and/or i	th occurred at the t	ime, date and place opinion, death occu	, and due to the	e cause(s) and m	anner as stat , and due to t	red. the cause(s)
	Markin Within Comp	Me	29b. Signature and title of certifier	fi			se number		Septe		
	20		30. Name and address of person who  BRICE SA  31. Date filed (Month, Day, Year)	completed cause of death (li		e, Print)	600	North W	olfe St, Ba	altimore	, MD, 21287
Bi	Regis	_	SEP 29			back					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 10, 200 Benton Louise Janice /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 99 Me Moria

5. Social Security Number Ta mbe 9. Orthplace (State or Foreign Country) Date of Birth (Month, Day, Ye Mar 18, 7. Age (In yrs. last birthday) **Funeral** Year Days Min. 1 □ M 2 □ ¥ 1948 236-76-1084 61 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County s 23a or 28a-f show 1 □Yes 2 □ No Cumberland MD Allegany **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any njury or other traumatic event, the Madral Exercises out being once. 21502 USA 515 Memorial Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Be Completed by white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Leary James Leary ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) MD 21502 Allen "Don" Benton Sr. husband Cumberland 515 Memorial Avenue Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Femation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 10/13/2009 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Part Home, PA 21. Signature of Funeral Sanio Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effects, or heart failure. List only one loause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death atria Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chuse (Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 ☐ No 1 ☐Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 10 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 5 Pending investigation 1 Natural n 24 hours after death.

The Funeral Director: After the function is the function of the function is the funct 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Dr

() BEUT

WELK,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

904

Registrar's Signature

SETON DR. CUMBERIAMO, MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BRENDA FAY CLAYTON 2009 3:55  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Hours Min. 215-56-1174 59 0477671950 MARYLAND Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director HARFORD 1 X Yes 2 No HAVRE DE GRACE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 709 GIRARD STREET 21078 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No AFRICAN Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: id Mental Hygiene. marked other than "natural", Completed 3 Widowed 4 Divorced **AMERICAN** Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RECORDS MANAGEMENT OFFICER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ ARTHUR M. JONES, JR pe CONSTANCE H. WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is n CONSTANCE H. JONES / MOTHER 7731 MAZATLAN DRIVE, EL PASO, TEXAS 79915 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 X Burial 2 Cremation 3 Removal from State ST. JAMES UNITED CEM. 10/07/09 HAVRE DE GRACE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME
552 LEWIS STREET, HAVRE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Gaquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 1 Tes Division of Vital Records. page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aw has autopsy performed certificate 1 Tes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 10 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical Within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 only one) Certifying Nurse, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Victor Hernandez Cruz 1- For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Time of Death 2048 hrs Medical Examiner October 5, 2009 Victor Hernandez Cruz 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Johns Hopkins Hospital Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign E 1
Country) Salvador Min. Months Days Hours Director 11-17-1968 40 None 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Y Yes 2 No or 28a-f show Prince George's Glen Burnie MD hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country El Salvador 21207 items 23a 1333 Lafayette Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married Never Married 2 X No Yes 1 X Yes 2 No specify: salvadoran 3 Widowed f Yes. Give Yea Divorced Specify: White ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 is marked other than within Prepared Food Restaurant permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Medi 7.th 17, Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Marta Cruz Garcia Paulino Cruz Elias 19a. Informant's Name/Relationship (Type, Print) (Sister-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7553 Kimberton Ct. Manassas, Virginia 20111 Togarma Beatriz Baten in-law) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation El Salvador Family Cemetery 10-21-09 Donation Other Specify 22. Name and Address of Facility W.H. Bacon Funeral Home, ure a Funeral S vice Licens 3447 14th St. N.W. Washington DC 20010. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician I. Ente Between Onset and lure. List only one cause on e /Medical Death Hanging mmediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ending physician use as the burial X UNPENDED AMENDED 23a,27,28a-f,perm,E g897 11/20/09 TT that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 ✓ Yes No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 this 1 Yes After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: Natural Pending Yes 2 X No subject hanged self in cell 24 hours after death. To the Funeral Director: Fd 10/5/09 Fd 1959 hrs 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be orTown, State) 40 E. Madison St Baltimore, M (Specify) jail cell Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 6, 2009 OCME Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Registrar's Signature

**ORIGINAL** 

State Registrar

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To th withir To th	Me	29b. Signature and	title of certifier				29c. Licens	se number		29d. D	ate signed (Mon	oth, Day, Year)
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State Registrar

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30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

C. BRETT HORMANN M.D. 100 E. CARROLL ST. SALIS bury Md. 21801

31. Date filed (Month, Day, Year)

32. Registrar's Signature

## Baltimore, Maryland 21215-0036

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Funeral Director		5. Social Security N 181–42–03	lumber		7. Age (In yrs 56	. last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da Apr 26	th ay, 1 <sup>Year)</sup>		thplace (State or Foreign ountry) PA
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Page tment ctant: If		4 ☐ Donation	5 Other (S		tate Ek	eneżer Church	United M Cemetery	leth 1		/2009	Sr	now Hil	l, MD
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Physician /Medical		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List (Final on	r complications that can only one cause on ea	used the dea	ath. Do not en	ter the mode of dyl	ng, such as	s cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burneral director.	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	! months? □No		irth 2□Fe ant at time o	tal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су				23d. Date of de Month	olivery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 🖖 🤍 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** phera 23 M 200 2 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month Day Year) Dec . 9, 1940 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Maryland 219-38-0046 68 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 28a-f show 1 X Yes 2 □ No none Washington, D.C. none items 23a or 28a-f s her must be notified Director 10g. Citizen of What Country? 10f. Zip-Code 20008 United States 3133 Connecticut Avenue, N.W., #714 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 Yes 2 No ō Baltimore, Maryland 21215-0036 Specify. ş 3 Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry th and Mental Hygiene.

7 is marked other than "natul traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Ruth Bornstein Samuel Dinowitz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3133 Connecticut Ave.,N.W.,#714 Washington,DC 20008 nt of Health a ; If item 27 is or other tra Lee Cohen -husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 10/11/2009 Alexandria, Virginia 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 A Cremation 3 □ Removal from State Department of Important; If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, Donal Maryland20705 4400 Powder Mill Road Beltsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. y pertension Onset and Death Immediate Cause (Final **Physician** mona disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of that initiated events nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALS 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has performed? 2 🗌 No Yes 2 🗌 No certificate the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \sum \) Nursing Home Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 5 Residence 6 Other (Specify) မ Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 2 🗌 No 1 Tes 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only one) Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number ES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Y

DHMH 17 Rev 1/2001

Barren

32. Registrar's Signature

6 2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Fleada 2008 acon 1 Cox /Medical 4a. Facility Name (If not institution, give street and number, City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Birthplace (State or Foreign Country)

PA Date of Birth (Month, Day, You Oct 21, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 □ E Days Months Hours Min. 215-26-6488 **Director** 1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemiter. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 □ ¥es 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 117 Arch Street 21502 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ **X**io 11 Marital Status 14. Bace - American Indian 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 □ No Specify. 3 Widowed 4 X Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finan Center secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Jay Stimely Ruth (Kane) Stimely ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 749 Maryland Avenue Cindi Bolyard daughter Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oliver Grove Cemetery 10/16/2009 MD Oldtown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Fun ral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part f. Enter the disea e or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Caure (Final disease or condition or condition)

a. Pue to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** hour /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the buriat-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) Tyes 2 THO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 □Yes 2 No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 ✓ No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1. Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

		For State	State	of Marylar		artment of H		ınd Men			0 2001	
		Registrar  1. Decedent's Name (First, Middle	(act)			incate of	Dealli	2 [	Re Date of Death	g. No.	3. Time of Death	
Physici		Frank L. Dani							Month	26 2009	ar	
/Medic Examir		4a. Facility Name (If not institution	, give street and n		2, 1	4b. City, Town, o	r Location of		•	4c. County of D	eath	
A		Shady Grove Adv				Rockvi.				Montg		
Funeral Director		5. Social Security Number 578–12–2546	6. Sex 1 ★ M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (	Date of Birth Month, Day, 11y 5,1	Year)	Birthplace (State or Foreign Country)  NC	
		Usual Residence of Decedent		07			11	100	TTA 21	722	140	
rylani show	_	10a. State 10b. County	*		ty, Town or Lo						10d. Inside City Limits	
Ba-fs	Director	DC		Wa	shingt						1 X Yes 2 □ No	
with the	ä	10e. Street and Number 729 Massachuset	ta Arroniu	NE		10f. Zip Code 20002			10	g. Citizen of What USA	Country?	
ns 23	Funeral	11. Marital Status		cedent Ever in U	.s. 13.1		lispanic Orio	in? (Specify	Yes or No-		merican Indian,	
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2 hour		15. Decedent	's Education		16a. Dece	dent's Usual Occup	oation		1	American 16b. Kind of Business/Industry		
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ed wit lygien ner th			4		Emp	loyment (					Maryland	
t be fill antal H sed oth	Be c	17. Father's Name (First, Middle, Dr. Frank L. Da		r./					rsı, mıaale, m Littl∈	aiden Surname) eiohn		
should Me mark	은	19a. Informant's Name/Relations		/	19b. Mailir	ng Address (Street				City or Town, Stat	e, Zip Code)	
and 2 salth a n 27 is		Barbara Fox/dau	ghter/		729 M	assachuse	etts A	ve., N	I.E.,Wa	shington	, DC 20002	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination is used to retified at once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)		n State Sp	ringhi.	sition (Name of natory or other pla LL Memory	ce)	Date		Hebron		
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cate be executed physician and the burial-transit	dical		<b>d</b>									
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With Con	Σ	29b. Signature and title of certifie  30. Name and address of person  31. Date filed (Month, Day, Year)	) no	)		29c. Licen	se number	243	5	9d. Date signed (M	onth, Day, Year)	
Bu		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print) le Cu	lar	$D_r$ .	Rock	cviller	MD20850	
Sta Registi	ite ar	31. Date filed (Month, Day, Year)	L 2009 32.	Pegistrar's Sign	ature.	arkel	_					

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			1 - State of Marylan Registrar		artment of H rtificate of L			giene Reg. No. 💯 [	1110	33242
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  JESSIE HALL EURE				2. Date of Dea Month SEPTEM	Dav	2009	3. Time of Death 11:30AM
	Examin		4a. Facility Name (If not institution, give street and number)  WILLIAM HILL MANOR		4b. City, Town, or <b>EASTON</b>	Location of Death		TALE	ty of Death	
	Funeral Director		5. Social Security Number 213–12–5477 6. Sex 1 ☐ M 2 ★ 7. Age (In yrs. 1 ☐ M 2 ★ 89	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da FEB. 5,	v. Year)	9. Birthp Coun MARY	
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	and 2 sho salth and 1 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) CLAIRE BAILEY/DAUGHTER	1	ng Address (Street a		ral Route Numbe	-		Code)
Baltimore,	Pages 1 annument of He		20a. Method of Disposition  1		sition (Name of matory or other plac GHILL	OCTO	Date BER 1	20c. Location	n - City or To	wn, State
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18760,	Physician /Medical Examiner physician and physician and the portal transit the purial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Solution list could fail fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conseq of the country of the countr	uence of):  L  L  L  L  L  L  L  L  L  L  L  L  L	Heart	Failu	ıl		C	Interval Between Onset and Death of the State of the Stat
O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending pi ral director, page 2 should be detached for use as I	by Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No  9 □ Unknown  23c. If yes, outcome of pregnate in the past 12 months?  1 □ Live birth 2 □ Feta in the past 12 months?  9 □ Unknown	Ideath 3	☐ Ectopic pregnanc	у		i	Date of delive	ery Day Year
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	To th within To th	Me	29b. Signature and title of certifier		29c. Licens		7	29d. Date sig		
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			Russell A Schilling 80 5	55 (	Znword	AV B	aston,	MD	210	001
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and ealth m 27		Anna Marie Yeager		709 Second St				21-1-
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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		21. Signature of Furleral Service License	Dean	Holloway F 107 Vine S	uneral Homo treet, Poc	e, Profess omoke Cit	sional Asso y, MD 21	ciation 851
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ÐN (		30. Name and address of person who co	700-101	23a) (Type, Print)	Sule 105	Poca	ul m	10)957-2112
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Registr	ar	OCT 0 1 2	009 Genera	B. Sarke				
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 18:40p<sup>M</sup> 09/29/2009 Sandra Margaret Edwards /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Peninsula Regional Medical Center Salisbury If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 59 Yrs. **Director** 10/07/1949 Virginia 187-40-1758 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1XYes 2 ☐ No Director Pocomoke City MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 403 Walnut Street 21851 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white à 3 Widowed 4 Divorced pleted 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Aubrey F. Goodwin

			1 - State of Mar State Registrar	-	epartment of Hea Certificate of De		entai Hygie Reg		15 00244
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Aubrey Fred Goodwin, Sr.				2. Date of Death Month	Day 29 20	3. Time of Death
_	Examir		4a. Facility Name (If not institution, give street and number) The Memorial Hospite	9/	4b. City, Town, or Lo	cation of Death		4c. County of D	eath $+$
	Funeral Director			In yrs. last birth Y	iday) If Under 1 Year if	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	Birthplace (State or Foreign Country)
yland	how		Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town	or Location				10d. Inside City Limits
ле Маг	8a-f s	Director	MARYLAND TALBOT	OXF					1 XYes 2 □ No
with th	Sa or 2		10e. Street and Number		10f. Zip Code			. Citizen of What	
death	ems 2;	Funeral	903 SOUTH MORRIS STREET  11. Marital Status  12. Was Decedent Eve Armed Forces?	er in U.S.	21654  13. Was Decedent of Hisparlf Yes, specify Cuban, N	anic Origin? (Spe			merican Indian,
5-0036 72 hours after death with the Maryland	giene. r than "natural", or items 23a or 28a-f show tte Medical Examinar must be notified at	by	1 Never Married 2 Married 1 Never S 2 No	1950- 1950	_	Specify:	iloan, etc.)	Black, W Specify: W	
2 2	n "natur Mudical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. [	Decedent's Usual Occupatio Give kind of work done durin life. DO NOT use retired)	on ing most of workin		b. Kind of Busine	ss/Industry
Z1Z1 ed within	ygiene ner tha t, tr	Com	10		SUPERVISOR			ANUFACTU	RING
and d be file	ental Hygi ced other c event, I	Be C	17. Father's Name (First, Middle, Last)  RICHARD H. GOODWIN				(First, Middle, Mai	iden Surname)	
aryl shoult	and Me s mark umation	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. I	Mailing Address (Street and			ity or Town, State	e, Zip Code)
<b>e, N</b>	ealth an 27 la		NORA MAE GOODWIN/WIFE		SOUTH MORRIS	S STREET			
S 8	Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)		Disposition (Name of crematory or other place)  CEMETERY			DXFORD.	or Town, State  MARYLAND
permit.	Departr Imports any inju once.		21. Signature of Funeral Service Licensee	2S.P.	22. Name and Address of FELLOWS, HEI 200 SOUTH HA	of Facility LFENBEIN	& NEWNAL	M FUNERA	L HOME, P.A.
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line,						Approximate Interval Between
	ysician /ledical		Immediate Cause (Final disease or condition resulting in death)	Pespin		ress Si	yndron	e	Onset and Death
	aminer		Due to (or as a c	onsequi nce of	):				71
pe	sit	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	onsequence of	):				
ob/ou, tificate be executed	ng physician and as the burial-transit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a continuous)  C.  Due to (or as a continuous)	onsequence of	):				.
oo/on	nysicia ne buri	ledical	d						
X 00	ding pl		IF FEMALE:						
death ce	atten d for us	Physician/N	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   23c. If yes, outcome of 1   Live birth   2   2   2   2   2   2   2   2   2	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year
at the C	d by the	Phys	9 ☐ Unknown						
rds, quires th	en signer vuld be d	ğ	Part II. Other significant conditions contributing to death but n	ot resulting in t	he underlying cause given ir	n Part I.	23e. Did tobac	N	e to the cause of death?  Probably 4 Unknown
RECORDS,	e has be ge 2 sho	Completed					24a. Was an autopsy	prior	autopsy findings available to completion of cause of
VII.dil ician: T	rtificate tor, pa	a	25. Was case referred to medical		26	3. Place of Death	performer 1 🗆 Yes (Check only one)	No 1□Y	
OI V	this ce al direc	To B			patient 3 DOA Other:		ne 5 Residenc	e 6 Other (S	Specify)
d find	After funera	tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day, You 2 Accident investigation 28a. Date of Injury  28a. Date of Injury (Month, Day, You 20a)	ear) 28b. Tir Inji	ury Work?	2 No	8d. Describe how	injury occurred	
or Attending	Director	ertification:	3 Deviside 6 Deput not be	- At home, farm Specify)	n, street, factory, office		8f. Location (Stree City or Town, S		Rural Route Number,
Hospital	whith the frouts after the teath of the the speen signed by the attending to the funeral birector. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of real manner stated and manner stated	amination and/	death occurred at the time, /or investigation, in my opinion	date and place, a ion, death occurre	and due to the caused at the time, date	se(s) and manne and place, and o	r as stated. due to the cause(s)
To the	To the	Mec	29b. Signature and title of certifier		29c. License nu		1	Date signed (Mo	onth, Day, Year)
	TLS		30. Name and address of person who completed cause of deat	h (Item 23a) (Ti		4488		4-29-	D 21601
	6		Bennett S, MD,	219 5	T. Washing	iton J.	+, Eas	ton, M	12 21601
	Sta Registra		31. Date filed (Month, Day, Year)  SEP 3 0 2009  32. Registrar's	Signature .	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Name (First, Middle, Last)

Physic		Carl George Gardi	Septemb				Day	Year 2009	10:45 P <sup>M</sup>		
/Med Exam		4a. Facility Name (If not institution, giv	e street and number	r)		4b. City, Town	, or Location of De			y of Death	
		Summerville Assis				Bowie If Under 1 Yea	u I Billadas 24 I	dra Ta a	Prince		
Funera Directo		230-44-1002	Sex 7.A	ige (In yrs. las 80	Yrs.	Months Day		Hrs. 8. Date of B lin. (Month, I Mar 21	Day, Year) 1929	9. Birthp Coun Ohio	lace (State or Foreigr try)
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				11	Dd. Inside City Limits
Mary a-f sho	햦	MD Prince Ge	eorge's	Bowie	≘				1 □Yes 2 📉N		
ith the	Director	10e. Street and Number				10f. Zip Code	•		10g. Citizen of	What Coun	try?
s 23a		16421 Lea Drive	L		Liai	20715		VD 14 14	USA		
and 21215-0036  be filed within 72 hours after death with the Maryland stal Hygiene.  Id other than "natural", or items 23a or 28a-f show event, it is Misdical Examinar mant be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 XYes 2	?				(Specify Yes or Nuerto Rican, etc.)		ice - Americ ack, White, e	etc.
DO3(	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1955-5	66	I∐Yes 2ŽAN	o Specify:		Speci	<sup>∜y:</sup> Whit	e
15-(	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)		16a. Deced (Give	dent's Usual Occ kind of work dor DO NOT use ret	cupation ne during most of ( ired)	working	16b. Kind of E	łusiness/Ind	lustry
2121 I within giene. r than "	dmo	Elementary/Secondary (0-12)	College (1-4or	<sup>(5+)</sup>	hysic		160)		Federal	L Gove	rnment
aryland 2 should be filed and Mental Hygi s marked other sumatic event, II	BeC	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (First, Middi	e, Maiden Surnai	me)	
aryla should to and Ment s marked umatic e	2	Carl George Gard	<u> </u>					enevieve	<del>-</del>		
Maryla d 2 should tth and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (						Rural Route Num	_		
or Healt of Healt item 27		Christopher J. Ga		20b. Plac		sition (Name of natory or other p		#32 Wash	20c. Location		
Pages Tent of ant: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif						10/01/09	Woodbir	ne, MD	•
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or any hijury or other traumatic event, the Madical Examples.		21. Signature of Funeral Service Licer	isee ///		GC GC	Name and Add	dress of Facility	ion Serv	ice P.C	). BOx	784 , MD 21029
		Hereit of the	2 MHC	MO1 2						ville	
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.				diac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical	•	disease or condition resulting in death)	a. Metastat	C1C MeJ s a conseque		a to Bra	in				
Examiner		Conventionalistics	Melanoma		_	nin					
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as	3 & Conseque	ice oi).						
execut and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or a:	s a conseque	nce of):						
760 te be e ysiciar e buria			. d.		,						
ortifical ing physics the	Medi	IF FEMALE:						144			
. BOX 68760, death certificate be executed e attending physician and d for use as the burial-transit	sician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗆 Fetal d	eath 3	Ectopic pregna				ate of delive	ery Day Year
	lysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of dea	ith 5∟	Other (specify)					
COTGS, P. Control of the control of	by Phys	Part II. Other significant conditions of	ontributing to death	but not resulti	ng in the ur	nderlying cause	given in Part I.	23e. Dio	I tobacco use cor	ntribute to th	e cause of death?
ords equire en sig								_   1□	Yes 2 No	3 ☐ Prob	ably 4 Unknown
4eCC e law r has be e 2 sh	Completed							24a. Wa	opsy	prior to cor	psy findings available
ate pag								per 1 □ Yes	formed? 2 <b>X</b> No	death? 1 ☐ Yes	2 □No
Ø (n :≡	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital:	tient 2 🗆 EF	2/Outpation	+ 2□ DOA		Death (Check only		has (O/	assisted
On of ding Phys h. After this funeral dii		27. Manner of Death	28a. Date of Inj	iurv 2	Bb. Time of Injury		jury at ork?	g Home 5 Re	how injury occur	rred	living—
VISION Attending or death. rector: After	catio	1 X Natural 5 Pending 2 Accident investigation	1	ay, reary	injury		□Yes 2□No				
DIVIS	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At home etc. <i>(Specify)</i>	e, farm, stre	eet, factory, offic	е		(Street and Num own, State)	ber or Rura	l Route Number,
DIVISION O To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical (	29a. Certifier 1	nysician: To the besininer: On the basis and manners	of examinatio	edge, death n and/or in	n occurred at the vestigation, in m	e time, date and pl y opinion, death o	lace, and due to the	ne cause(s) and n e, date and place	nanner as s , and due to	tated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier					nse number		29d. Date signe	ed (Month,	Day, Year)
		Vet so	- mp			D569	77		Septemb	er 30	, 2009
3th		30. Name and address of person who	·			,					
S	ate	Peter Su, M.D. 14 31. Date filed (Month, Day, Year)	38 Defens	SE HWY . trar's Signatur	Suit	e 201 G	ambrills	, MD 210	54		
Regis		OCT 12	2009 Sens	trar's Signatur	1. A	arked					
DUBILLAZ David	2001										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Date of Death Month

3. Time of Death

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla		rtificate of		, ,	eg. No.			
	Physici	an	1. Decedent's Name <i>(First, Middle, La</i> <b>Charles</b> U	st) Usher Gartner			-	2. Date of Death	12, 200 <sup>9</sup> ar	3. Time of Death 8:07 AMM		
a garage	/Medio		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat			
and de			Citizens Care & F		rick		Frederic					
ı	Funeral Director		5. Social Security Number 212-03-1389  Usual Residence of Decedent	Sex 7. Age (In yr SYM 2□F 89	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 14	4, 1919 M.	thplace (State or Foreign ountry) aryland				
	ryland thow	_	10a. State 10b. County 10c. City, Town or Location									
	the Ma	ecto	Maryland Freder:	ICK F1	rederic	10f. Zip Code			0g. Citizen of What Co	1 □ Yes 2 No		
	ath with 1	<b>Funeral Director</b>	8425 Edgewood Cl			217			U.S.A.	y:		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer mat be neithed at once.	ğ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Mayes 2 □ No If Yes, Give WW I		Was Decedent of H If Yes, specify Cub 1 □Yes 🙀 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: W			
21215-0036	hin 72 ho e. an "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	(Give		during most of wor d)	king	16b. Kind of Business/				
2	ed wit lygien ner tha	Con	Elementary/Secondary (0-12)	College (1-4or 5+)	Super	rvisor/ S	hipping		Manufact	uring		
/lanc	uld be fil Mental H Irked otl Itic ever	To Be	17. Father's Name (First, Middle, Last Albert L. Gar					ne <i>(First, Middle, N</i> e Gertrud	de Miller			
Mar	ind 2 sho alth and 27 is ma er trauma		19a. Informant's Name/Relationship (	**					; City or Town, State, 2 ederick, M			
Baltimore, Maryland	Pages 1 and the ment of He ant: If item		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State M	Place of Dispo cemetery, cren ount 01:	natory or other plai	etery Oct	Date . 16, 200	20c. Location - City or 09 Freder:	,		
Bait	permit. Departr Importa any Inju		21. Signature of Foreral Service Licensee  M00255  M00255  M00255  M00256  M00256  M00257  M00256  M00257  M00257  M00257  M00258  M00258  M00258  M00258  M00258  M00258  M00259  M00									
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the de one cause on each line.	ath. Do not ent	er the mode of dyl		~		Approximate Interval Between Onset and Death		
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to (or as a conse	-	ENTIA				DAYS		
		iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	bDue to (or as a conse	equence of):							
68760,	icate be executed physician and the burial-transit	Medical Examiner										
O. Box 68	atth certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of de Month	livery Day Year						
ds, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.		pacco use contribute to	ise contribute to the cause of death?		
ecords,	w requ	letec					· ·	24a. Was ar		utopsy findings available		
Ï	The rate har page	Completed						autops perforn 1 □ Yes 2	ned? death?	completion of cause of s 2 □No		
Vital	Physician: The r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		t 3 DOA Oth		ath (Check only one	<u> </u>			
o	ding Physician:  After this certific funeral director,	2	1 Yes 2 ► No  27. Manner of Death	1 ☐ Inpatient 2 [ 28a. Date of Injury (Month, Day, Year)		IL 3 LI DOA	4 Le Nursing H		ence 6 Other (Spe	cify)		
מסוג	ending sath. or: Afte he fune	ation	1 □ Natural 5 □ Pending 2 □ Accident investigation	1	Injury		kí?  Yes 2 □ No					
DIVISION	al or Attending F s after death. I Director: After d in by the funers	Certification:	3 Suicide 6 Could not b 4 Homicide determined		home, farm, stre cify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ri n, State)	ural Route Number,		
	The state of the s								s stated. e to the cause(s)			
	To th	Me	29b. Signature and title of certifier	1		29c. Licens			9d. Date signed (Mont	-		
			30. Name and address of person who	completed source of death (It		1100	6/4-10	2	OCT, 13	, 2009		
			30. Name and address of person who	_	em 23a) (Type, 1	Toll	HOUSE	Hy	FREDER	2 (CK MD		
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 0							

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 09 2009 9:15 P 25 EDWARD KEITH HARRISON

Physician /Medical

	Examir	ier	4a. Facility Name (If not	institution, give s	treet and nun	nber)		4b. City,	Town, or	Location of	f Death		4c. Co	unty of Deat	h
	۰		GENESIS HE	SALTH CA	RE THE	PINES				STON				TALB	
	Funeral Director		5. Social Security Number 215–20–2558	3 <sup>1</sup> X	M 2□F	7. Age (In yrs. la	a <i>st birthd</i> ay) Yrs.	If Under Months	n 1 Year Days	If Under 2 Hours	Min.	B. Date of Bi (Month, D 06–30-	ay, Year)	9. Birt	hplace (State or Foreign untry)  MD
	aryland show	r	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits				
	ith the Mi or 28a-f	Director	MD 10e. Street and Number	TALBO	T			10f. Zip	EAST Code	ON			10g. Citizen	of What Co	
	23a		29300 WILL	STREET					21	601			Į	J.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantina court by pulling at once.	by Funeral	11. Marital Status  1 Never Married	2X Married	Armed For 1 Yes If Yes, Giv	2 □ No e		Vas Deced Yes, sped □Yes		spanic Orig n, Mexican, Specify:	jin? (Spec Puerto Ri	ify Yes or Nican, etc.)	0- 14.		rican Indian, e, etc.
00	hour:		3 Widowed 4		Ye ar or Da	tes: 1945	10- D	lamble I face	-1.0	-4:					WHITE
75	in 72 "nat	Completed	(Specify or	Decedent's Educ nly highest grade	completed)		16a. Deced (Give I life, D	kind of wo	rk done d	luring most	of working	7		of Business/	STRIBUTOR
212	within jiene. r than "	шо	Elementary/Secondary	y (0-12)	College (1-	-4or 5+)	WAREH			ERVIS	OR		DEVAL	age Di	SIKIDOLOK
þ	il Hyg other	Be C	17. Father's Name (First	t, Middle, Last)			WILLIAM	OUDII	501			First, Middle	, Maiden Sui	rname)	
lan	ld be fenta ked ked	To B	ERED SM	TH HAR	RTSON					T.	T.RAN	ו.וא או	ZA LON	AY.	
ar.y	should and Men and Men marke	-	19a. Informant's Name/I				19b. Mailin	g Address	S (Street a				ber, City or To		Zip Code)
Š	nd 2 aith a 27 is 27 is		HENRIETTA	L. HARR	ISON	WIFE	2930	o wii	LL ST	REET.	EAS	TON. N	D 2160	)1	
altimore, Maryland 21215-0036	ages 1 a ent of He nt: If item 'y or othe		20a. Method of Disposition 1 ■ WBurial 2 □ Cre 4 □ Donation 5 □	ion emation 3 🗆 R		state	ace of Dispos emetery, crem	sition (Nar natory or c	me of other place	e)	Da	te		ion - City or	
Baltin	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral		1/0~		FE	Name ar	nd Addres	s of Facility	EIN	& NEW			HOME, P.A.
			23a. Part 1. Enter the dis	canno ar compli	options that as	used the death	20	OS.	HAR	RISON	ST.,	EAST	ON, MD	2160	Annrovimato
	Physician /Medical	i n	shock, or heart fail Immediate Cause (Final disease or condition resulting in death)	lure. List only on	e cause on ea	schemit	c a	er the mod	or ayın	y opoli	tiy	respiratory	arrest,		Approximate Interval Between Onset and Death  Mean S
	Examiner	J.		ns, b	Due to (	or as a consequence as	ence of):		)		/				years
<u>,</u>	executed in and ial-transit	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c c	A	therose or as a consequ	Levosi	Ĭ							years
Box 68760,	rtificate be ng physicia as the bur	ledical		d											- 18-W - 19-5-
o.	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregin the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	1 Live b	come of pregnal irth 2  Fetal ant at time of de own	death 3	Ectopic p Other <i>(sp</i>					23d	. Date of de Month	ivery Day Year
σ,	s that ned b	y Ph	Part II. Other significant	t conditions con	tributing to de	ath but not resu	Iting in the un					23e. Did	tobacco use	contribute to	the cause of death?
ords	w requires t s been signe should be	0	Chron	nic obs	tructi	Va pul.	mona	ry d	isea	se		12	Yes 2□N	No 3□P	robably 4 🗌 Unknown
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/ita	sician: Th certificate rector, pag	Be	25. Was case referred to examiner?	-			48 - 40	200			of Death (	Check only	one)		
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sion o	ending Path.	ation:	2 Accident	☐ Pending investigation	28a. Date of (Monti	of Injury h, Day, Year)	28b, Time of Injury	M	28c. Injury Work 1 □ \	∕at ? ∕es 2 □ N		3d. Describe	how injury or	ccurred	
Dİ <u>X</u>	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num City or Town, State)							lumber or Ri	ural Route Number,				
	he Hospi in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one)	Certifying Phys Medical Examir	ician: To the ner: On the ba and mann	isis of examinat	vledge, death ion and/or inv	occurred estigation	l at the tin	ne, date and pinion, deat	d place, ar th occurred	nd due to the d at the time	e cause(s) an , date and pla	nd manner a ace, and due	s stated. to the cause(s)
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ner	4a. Facility Name (If not institution, give					ŕ			ity, Town, or			1		4c. Cour			
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eted		(Spec	15. Deceden	nt's Educ	ation completed)	)		Decedent's U (Give kind of	work done d	durina mo	st of wor	king	16	b. Kind of	Busine	ss/Indi	ustry
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Be Co	17	7. Father's Name	(First, Middle,	Last)							her's Nam	ne (First, Mic					
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								WATSO	JN F.	н	3435	14tr	ı SI	' N.	Ν.	WAS	SH. DO
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  A 1 D S  Onset and D  Due to (or as a consequence of):  Due to (or as a consequence of):  A 1 D S												ry arrest	t,			Approximate Interval Betwee Onset and De
xaminer	Sif ciC	mmediate Cause ( disease or condition esulting in death) sequentially list contain, leading to imple any, leading to imple ause. Enter Unde ause (Disease or nat initiated events	(Final on moditions, impediate ritying injury s	b.	Due to	or as a construction of the construction of th	sequence of	Dec 1): Delor	mode of dyin		is cardiac		ry arrest	t,			Approximate Interval Betwo Onset and De
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / Dep		Health and I	Mental Hyg	_	4	33240
			Decedent's Name (First, Middle, Last	r)				2. Date of Death	h		3. Time of Death
***	Physici /Medio	cal	Martha Elizabet 4a. Facility Name (If not institution, give	h Hanson		4b. City, Town, o	or Location of Death	Sept	24 20 4c. County of		0756 <sup>M</sup>
	Examir	ier	Carroll Hospital			Westmi				rrol	1
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,			lace (State or Foreign
	Director		235-09-6392 Usual Residence of Decedent	⊒м а <b>ў</b> ⊋ F	94 Yrs.	Months Days	Hours Min.	July 04			W. VA
	ylan		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	a-f s	cto	MD Carro	11	West	minster					1 □ Yes 2 □ No
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Examiner rust be multipled at	Funeral Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of Wh		try?
	ath w	ā	301 Niner's Pri	vate Road			1157		US		
	tems	nne	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Pican, etc.)	14. Race - Black,	Americ White, e	an Indian, etc.
36	or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2√ N If Yes, Give	0	1 ☐ Yes 2 🙀 No	Specify:		Specify:	TATI	nite
8	hour tural	ed t	15. Decedent's Edu	Year or Dates:	16a Dec	edent's Usual Occu	nation	1	16b. Kind of Busi		
15	n 72 n "na	olet	(Specify only highest grad	le completed)	(Giv	e kind of work done DO NOT use retire	during most of worked)	king	TOD: TAING OF BOOK	11000,1110	Subity
21215-0036	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	r)	Homemake			Own Ho	me	
D	filed I Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)				Т	e (First, Middle, N	faiden Surname)		
lan	ld be lental ked o	To B	James Armentrout				Effie 1	Huffman			
Maryland	should and Mer s marke umatic	-	19a. Informant's Name/Relationship (T	ype. Print)	19b. Mai	ling Address (Street	t and Number or Ru	ral Route Number,	, City or Town, Si	tate, Zip	Code)
	nd 2 alth a 27 Is 27 Is		Debbie Hanson/dau	ghter	301	Niner's I	Private R	oad West	minster	, MI	21157
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be muffled at once.		20a. Method of Disposition		20b. Place of Disp	position (Name of ematory or other pla	(9/28)	P2009	20c. Location - C	ity or To	wn, State
Ę	Page nent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		1	en Memoria			Finksbu	rq,	MD
alti.	mit. I		21. Signature of Juneral Servica Licens			PHICES APP					
ä	permi Depar Impor any fr	1	I John to	-	- 4		ington Ro				21157
1	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not end e. ASAA consequence of):	nter the mode of dyi	ing, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any leading to immediate cause. Energy Janyi ay Cause (Disease or injury	b. Due to (or as a	a consequence of):					- 1	
,092	icate be executed physician and s the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a	a consequence of):						
687	ficate phys s the			d	· · · · · · · · · · · · · · · · · · ·						
O. Box (	Hospital or Attending Physician: The law requires that the death certificat 4 hours after death. Funeral Director: After this certificate has been signed by the attending phy telety filled in by the funeral director, page 2 should be detached for use as the left filled in by the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date Mont		ery Day Year
s, P.	res that the de signed by the a be detached to		Part II. Other significant conditions co	ntributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.		-		ne cause of death?
õ	w require s been siç should b	ted									Sabiy 4 Gridiowi
Records,	The law cate has b page 2 sl	Completed by		·				24a. Was ar autops perforn 1 □ Yes 3	y pri ned? de	or to co ath?	psy findings available mpletion of cause of 2 ☐ No
Vital	i <b>lcian:</b> The certificate ector, pag	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only on			
<b>*</b>	Physician: this certifical	2	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ER/Outpation	ent 3 ☐ DOA Otl	her: 4 D Nursing H	ome 5 🗆 Reside	ence 6 Other	(Specif	y)
ion of	nding Ph tth. r: After th e funeral	ation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time (, Year) Injury	Wo	iry at rk? ]Yes 2 □ No	28d. Describe ho	ow injury occurred	·	
Division	al or Attendi s after death. Il Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (St. City or Town	reet and Number n, State)	or Rura	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (		vsician: To the best of iner: On the basis of and manner sta	examination and/or						
	To the within 2. To the Complet	Me	29b. Signature and title of pritifier		4.4 3	29c. Licen		2	9d. Date signed	Month,	Day, Year)
			1 Thata	· May	- MO	poc	059552		9/24/	2009	7
1	ortio		30. Name and address of person who co	0			le RD U	VESTOMA IS	7/		
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature	, , , ,	C PU	-311-11103	110	الاحب	
	Registi		SEP 28 2	1 2	in A. x	parker					

#### 09-07865 Timothy L. Hornsby

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mothy L. Hornsb	1	State of Maryland / Department - For State Certificate			and	Mental	Hygie		g. No.		0 2325
Physician	1	Registrar  1. Decedent's Name (First, Middle, Last)  Timothy Levi Hornsby					N.Ar	ate of Death	Day Year		3. Time of Death
edical Examine		Timothy Levi Hornsby  4a. Facility Name (if not institution, give street and number)	4	b. City, To	n, or Lo	cation of D		tober 10	4c. County of	Death	
	ı	Peninsula Regional Medical Center		Salisbu	<u> </u>				Wicomico		
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	1	If Under Months	Year Days	If Under 24 Hours	Marin		Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Merry land		
Director	L	218-04-4617   1X M 2 F   25	Yrş.	<u> </u>				1/22/	1984	Pic	Eyland
any	t	10a. State 10b. County 10c. City, Town or Lo									10d. Inside City Limits
Maryland 28a-f show 1 at once		Maryland Wicomico Salis	sb					10	g. Citizen of Wha	- 1	1 X Yes 2 No
or 28a-f sho	10e. Street and Number 10f. Zip Code 21804								USA		
			Wa	s Decedent es, specify	of Hispa	anic Origin?	( Specify	Yes or No-	14. Race - White,		an Indian, Black,
or iter	runeral	Never Married 2 Married 1 Yes 2 X No		Yes 2			Terto Micar	1, 010.)	Specify:	white	
urs afte	함.	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	den	t's Usual O	cupatio	n (Give kin	d of work o	done	16b. Kind of Busi		
036 tthin 72 hours ne. r than "natur	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	•	ost of worki	ng life. D	OO NOT us	e retired)		n 1 all	L 170.	B
5-0036 led within 72 Hygiene. other than	<b>E</b>	11 – line 17. Father's Name (First, Middle, Last)	es	man	18	3.Mother's	Name (Firs	t, Middle, N	ASPTUNOI Maiden Surname)	<u>n 11</u>	ree Experts
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	8 8	Thomas Wayne Hornsby, Sr.						ie Mc			
U di B is i≝ [		1 1 1							nber, City or Town,		1
and 2 shou tealth and N item 27 is n traumatic	ŀ	20a. Method of Disposition 20b. Place of Dis	pos	ition (Name			Da		20c. Location - 0		
more		Burial 2 X Cremation 3 Removal from State Salisbur	r oti	r Cren	ator	y 1	.0/13	/09	Salisb	ury	, MD
Baltimore, MI permit. Pages I and 2.9 Department of Health a Important: If item 27 Important	İ		<sup>2</sup> H	Welle.	ddress f	uñera	il Ho	me Pr	ofession	al	Association 804
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter									Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Oxycodone intoxi									Between Onset and Death
xaminer	١	or condition resulting in death) Due to (or as a consequence of):									
	اةِ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	_								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	_								
ecuted and - transi		d	<u>. n</u>	er MF	280	6 10	/21/0	9 TT			
e be ex	edical	X UNPENDED AMENDED 23a, 27, 20a-1  IF FEMALE: 23c. If yes, outcome of pregnancy	<b>,</b> P		80.				23d. Date of o	deliver	,
30x 6876( death certificate e attending phy for use as the t	Physician/M	23b. Was decedent pregnant in the nast 12 months?	Fe	etal death	3	Ectopic p	regnancy		Month	C	Day Year
Box ( e death ce the attence of for use	ysici	1 Yes 2 No 9 Unknown g Unknown	0	ther (Spec	fy)				60kč		
P.O. Bost that the degree by the edetached f		Part II. Other significant conditions contributing to death but not resulting in	the	underlying	ause gi	ven in Part	l.			_	the cause of death?
S, P.C	ed by						— JJ	1 Yes			topsy findings available
Division of Vital Records, rat or Attending Physician: The law require rs after death.  al Director: After this certificate has been sited in by the flueral director, page 2 should be a managed.	Completed						_	autor perfo	osy pi rmed? d	rior to c eath?	completion of cause of
Vital Recysician: The his certificate director, page	e Co	25. Was case referred to medical			6.Place	of Death (C	heck only	1 Yes	2 No 1	<b>✓</b> Ye	es 2 No
Vita hysician this cer	o B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpa	tien				Nursing H		Residence 6	Other	·
n of ding Ph	on:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time (Month, Day, Year)		· ·	-	y at Work? es 2 🗓 N			how injury occurre	)d	
isior Attender death rector:	icati	2 Accident Investigation 28e. Place of Injury - At home, farm,						Location (	Street and Number	r or Ru	ral Route Number, City
Div pital or ours aft eral Di	Certification:	Suicide 6 Could not be determined (Specify) found at h	on	ne 			Sa	Tisbu	ry, MD		ше вс
		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) Wedical Examiner:On the basis of examination and/or investigation.	occu stiga	arred at the	time, da opinion,	te and plac	e, and due	e to the cause time, date	se(s) and manner and place, and d	as stat ue to th	ed. e cause(s)
To the with com	Medical	and manner stated.  29b. Signature and title of certifier				number			29d. Date signe		<del></del>
		Land. It			O.C.1	Л.E.			October 11	, 200	9
		30. Name and address of person who completed cause of death (Item 23a)	P-	enn Stree	t Ralt	imore M	1D 2120	1			
Sta	to		_	and Street	i, Dail		۷۱۷ ک ت	1			
Renistr		31. Date filed (Month Pay, Yaar) 2009 32. Registrar's Signature	196	MARINE							

			For State Registrar	State of Mar		epartment of Healt Certificate of Dea			ene	0 2225
			1. Decedent's Name (First, Middle, Last	)				Date of Death		3. Time of Death
	Physici: /Medio		Donna Lynn Harr	ington			3	Month 3	Day Year 2009	7741 M
S. Roy	Examin		4a Facility Name (If not institution, give	street and number)	,	4b. City, Town, or Locat			4c. County of Dea	
أاس				Medical Co	enter	SMISDE	ury		Wica	
×	Funeral Director		5. Social Security Number 6. Se 267-46-2823	x 7. Age (	In yrs. last birth	Months Days Hou	ure Min	Date of Birth (Month, Day, You 19 28,	ear) C	thplace (State or Foreign ountry) aryland
5	2 *		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
Aaruk	f sho	or	MD Wicomic		3.	, Leoditori				1 □ Yes 218X1No
9	r 28a	Director	10e. Street and Number		Delmar	10f. Zip Code		10g	. Citizen of What C	ountry?
H.	23a o	al D	9329 Colonial Mil	l Drive		21875	5		U.S.A.	
5-0036	inter within 2 mous and beam with the matyral that Hygiene.  do other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be motified.	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of Hispanio If Yes, specify Cuban, Me:	ic Origin? (Specif exican, Puerto Ric	y Yes or No- ean, etc.)	14. Race - Am Black, Whit	
)36 []	", or l	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 □Yes 2 No Spe	ecify:		Specify:	white
5-0036	atura	ted	15. Decedent's Edu	cation	16a. [	ecedent's Usual Occupation		16	b. Kind of Business	
2 5	an "n	Completed	(Specify only highest grad	College (1-4or 5+)		Give kind of work done during ife. DO NOT use retired)	most of working	I		
2 3	Hygier ther th		10			Homemaker			Home	
Maryland	ed of	Be	17. Father's Name (First, Middle, Last)			18. N	Mother's Name (F			
<b>Y</b>	and Mental is marked o	입	William Lester Ca  19a. Informant's Name/Relationship (T)		19b. I	Mailing Address (Street and No	Elizabe			Zin Code)
	of Health and Men litem 27 is marke other traumatic		Eric Lee Harringt			7 Tower Road	Wyomir		19934	_,p
altimore,			20a. Method of Disposition			Disposition (Name of crematory or other place)	Date		c. Location - City or	Town, State
imor	ment of and or and or and or		1 A Burial 2 ☐ Cremation 3 ☐ B 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		o Memorial Par	rk Oct. 3	3,2009	Salisbur	y, Maryland
Balt	Department of more state of the		21. Signature of Funeral Service Licens	Lewell		22. Name and Address of F Short Funeral 13 East Grove		Delma:	r, DE 19	940
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the	e death. Do no	_				Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	Tom	c me	sarolen				Onset and Death
	/Medical xaminer		resulting in death)	Due to (or 4s a c	consequence of	check				
		e	Sequentially list conditions,	b	Consequence of					
uted	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	_						
o, exec	an an rial-tr		resulting in death) Last	Due to (or as a c	onsequence of	:				
ecords, P.O. Box 68760, aw requires that the death certificate be executed	physician and s the burial-transit	edical		d						
Sertii 6	ding p	/Mec	IF FEMALE:	23c. If yes, outcome of	pregnancy				I	
Box leath cer	been signed by the attending the should be detached for use as	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at tir	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	Day Year
at the d	by the	hysi	1 □ Yes 2 No 9 □ Unknown	9 Unknown						
S, F	gned l	by P	Part II. Other significant conditions co	ntributing to death but r	not resulting in t	he underlying cause given in F	Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
	sen siç							1 ☐ Yes	2 No 3 F	Probably 4 Unknown
VITAL RECORDS, ician: The law requires to	as be	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<b>E</b> 12	certificate has t	Con						performe	d? death?	
VIT ician	certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:		T <sub>au</sub>	Place of Death (C	Check only one)		
Phys	ral dir	.T	1 Yes 2 No	1 Inpatient 28a. Date of Injury	2 ER/Outp	attent 3 DOA 4L		5 Residence  d. Describe how	ce 6 ☐ Other (Sp.	ecify)
	th. : Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Y		ne of 28c. Injury at Work?  M 1 □Yes		J. Describe flow	injury occurred	
DIVISION OF	ector ector by the	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farn	street, factory, office	28f			Rural Route Number,
<u>ה</u>	rs afte	Cert	4 El Hornioldo	building, etc. (	ореспу)			City or Town, S	State)	
je Hospi	within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	ner: On the basis of ex	xamination and	death occurred at the time, da for investigation, in my opinion	n, death occurred	at the time, date	e and place, and du	as stated. e to the cause(s)
_ To #	withi To tl	Me	29b. Signature and title of certifier			29c. License numl	ber	29d	I. Date signed (Mon	th, Day, Year)
R	an		1		620	H001	(-)4/2	) /	10/1/89	9
-	Dag		30. Name and address of person who co	ompleted cause of deat	th (Item 23a) (T	29c. License numl  # 00 s  /pe, Print)  //KO// St.	11/11/	un - m	16	
	Sta	te	31. Date filed (Month, Day, Year)	32/Registrar's	Signature	1 11	3401300	ay m	/ ()	
	Registr		OCT 0 2 200	9 Determ	A. 1	Jane		=		
				-						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥍 📗 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October Physician/ BEULAH C. HARRIS :03 AM 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** WASHINGTON WASHINGTON COUNTY HOSPITAL **HAGERSTOWN** Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 4/25/1910 Year) Hours 234-01-8092 1 ☐ M 2 ☐**(**F 99 WEST TRGINIA **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23a or 28a-i shor ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MARTINSBURG W۷ BERKELEY 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 25404 1415 ECHO STREET USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) TRUCKING COMPANY Elementary/Seconday (0-12) College (1-4 or 5+) OWNER Be 18. Mother's Name (First, Middle, Maiden Surname)
MAUDE CROUSE 17. Father's Name (First, Middle, Last) ည CHARLES B. CLOUD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 1415 ECHO STREET, MARTINSBURG, WV 25404 LINDA C. GUEST/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 K Burial 2 Cremation 3 Removal from State ROSEDALE CEMETERY MARTINSBURG, WV 2009 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 les 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ a disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year ate has been signed by the page 2 should be detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIVERTICULTIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? After this certificate 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to m all 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) mull Deered ) Octuber 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5T Dan 10() 10 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend I tems 10b, C.e. f. per FH G898 10/16/09 dk.

State of Waryland Department of Health and Mental Hygiene

		•	For State Registrar	Otato of mary are	Certificate of	Death	Reg.	No.	00205
14. •	Physicia	_	1. Decedent's Name (First, Middle, Las	Hiner			2. Date of Death	Day Year	3. Time of Death  5.00 M
)	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	r Location of Death		4c. County of Death	1 1 - 054
Sept.	Funeral		5. Social Security Number 6. So	ex 7. Age (In yrs. Ia	ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Ye	9. Birthp	lace (State or Foreign
ž.	Director		Usual Residence of Decedent	0 1	Yrs.		June 24, 19	20 Penr	iśylvania
	aryland show d at	_	N	nce Georges <sup>oc. City</sup>	, Town or Location	222244	- Belts	sville	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f notifie	irecto		Montgomery Road	d 10f. Zip Code	20705	N	Citizen of What Cour	
	ath with	Funeral Director	3-44-2	Kind-was		\$ 3-6-€		United Sta	
	ifter de		11. Marital Status 1 ☐Never Married 2☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 Pes 2 No	If Yes, specify Cub		city Yes or No- Rican, etc.)	Black, White,	etc.
	filed within 72 hours after death with the Maryland Hygiene, Hydiene, wither than "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	d by	3 ∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No 16a. Decedent's Usual Occup	Specify:	161	Specify: 1/20. Kind of Business/Inc	hite dustry
	hin 72 e. an "nat Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of workin	g		lustry
7	filed wit Hygien ther the nt, the		17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name		own home	
la l	uld be i Vental Irked o	To Be	Frederick Heidorn			Mary Jane	Marsh	,	
Mai	and 2 sho alth and 1 27 Is ma er trauma	Ė	19a. Informant's Name/Relationship (7 Robert E. Hiner -	• • • • • • • • • • • • • • • • • • • •	19b. Mailing Address (Street 11211 Montgom				
בי בו	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Both important: If them 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Nethod of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State R16	lace of Disposition (Name of emetery, crematory or other pla CNLANG Cemeter	y 10/9/2		hns town, Pe	own, State ennsylvania
Dall	permit. Departr Importa any inju		21. Signature of Funeral Service Licen	See facha)	Donald V. 4400 Powde	Borgwardt r Mill Roa	Funeral d Beltsv	Home, PA ille, Mary	land 20705
R			23a. Part1. Enter the disease, or company shock, of heart failure. List only	plications that caused the death one cause on each line.					Approximate Interval Between Onset and Death
į	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.  Due to (or as nsequ	SEPSIS				
	Examiner	la.	Sequentially list conditions,	b. Due to for as a conseque	VGRENE (L	FOOT			
	cuted id	Examiner	Sequentially list conditions, if any, leading to innect at cause. Enter Underlying Cause (Disease or injury that initiated events	c.	is not on.				
, o	rificate be executed ig physician and as the burial-transit	al Exa	resulting in death) Last	Due to (or as a consequ	ience of):				
00	ertificate ing phy e as the	Medic	IF FEMALE:		41-				
.O. DO.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 ponths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnance	y		23d. Date of delive	ery Day Year
COLUS, T	quires that n signed b ald be deta	by	Parkli. Other significant conditions of	ontributing to death but not resu ASCULAR	ulting in the underlying cause given by USEASE	ven in Part I.		co use contribute to t	
חשבו	The law re ate has bee page 2 sho	Completed	ATRIAL FIBR	ILLATION			24a. Was an autopsy performed	prior to co	opsy findings available mpletion of cause of 2 ☐ No
\     \	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	ED/Outrationt 25 DOA Ott	26. Place of Death			
5	ng Phy fter this neral di	on: To	27. Manuer of Death Natural 5 Pending	1 ☐ Inpatient 2 ☐ I  28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DOA 28c. Injury 28c. Injury		8d. Describe how	e 6 □Other (Special Injury occurred	у)
DIVISION	ttendir death. ctor: Al	icatic	2 Accident investigation 3 Suicide 6 Could not be			]Yes 2□No	8f. Location (Stree	et and Number or Run	al Route Number.
2	tal or A rs after al Dire	Certification:	4 Homicide determined	building, etc. (Specify	)		City or Town, S	State)	,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		ysician: To the best of my know niner: On the basis of examinat and manner stated.					
_	To the within To the Comp	Me	29b. Signature and title of certifler	Lallani	29c. Licen	9595		Date signed (Month, $10/6/00$	
			30. Name and address of person who	completed cause of death (Item	23a) (Type, Print) 835 SmITH A ture	VE, SuiT	= 203,	BALTO N	1) 21209
	Sta		31. Date filed (Month, Day, Year)	32. Registrats Signal	ture	0			
DII.	Regist	rall	oci 1	DEUD Cenus	U B. APANSO				

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 10:00 am 2. Date of Death Physician/ October 10, 2009 Rita Faye Holcomb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heart Heritage Street Harford Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Min. 1 □ M 2 🔀 F Hours 11/12/1923 Virginia Director 216-18-0274 85 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Aberdeen 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3416 Walnut Road 21001 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White 3€XWidowed 4 □ Divorced Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 1ž Switchboard Operator permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Insurance Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wiley Plummer Jettie Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Wilson (Daughter) 866 Woodmont Rd. Annapolis, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gdns. 10/13/09 Bel Air, Maryland 21. Signature of Funeral Service Licenses <sup>22</sup> Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or comblidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ 1200 Stril disease or condition resulting in death) **Medical** Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate
Cause (Disease or iinjury Examine Due to (or as a consequence of) and I-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 🗌 Yes 1 Yes 2 No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1300 examiner? 1 🗌 Yes 2 No CARL 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Specify after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after brec the Hospital

State Registrar

within 2

2

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Medical

29a, Certifier

29b. Signature and title of certifier

DLARAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SPARILS

415 W. MACPHAIL

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Bel Dan MA 21014

			For State	State of	of Marylan	•			Mental Hygie		-	, pag 10 149
			Registrar			Cel	rtificate of L	Death		. No.	1115	-11200
	Physicia	an	1. Decedent's Name (First, Middl	e, Last)					Date of Death     Month	Day	Year	3. Time of Death
	/Medic		Eunice Lake Ja	mes					October	2 2	2009	5:10 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution	n, give street and no	ımber)		4b. City, Town, or	r Location of Death	1	4c. County	of Death	
			Chesapeake Woods (	Center 525	Glenburn	Avenue	Ca	mbridge		1	Dorche:	ster
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year		8. Date of Birth (Month, Day,	(oar)	9. Birthp	lace (State or Foreign
	Director		218-24-5966	1 □ M 2 🗓 F	81	Yrs.	Months Days	Hours Min.	January 29			ryland
	T)		Usual Residence of Decedent									
1	/lan		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
7	Mar	to	Maryland Dorch	nester		Cambridg	۵					1 X Yes 2 No
3	the 288	Director	10e. Street and Number	ICDCCL		20022109	10f. Zip Code		100	g. Citizen of	What Cour	ntry?
۷	with a or		004 17-1:					1612			TICA	
7	sath	Funeral	824 Washington St		edent Ever in U.	S 12 1		21613	necify Ves or No-	14 Ra	USA ce - Americ	an Indian
	item item	ᆵ	11. Marital Status	Armed F	orces? 2 🔀 No	0. 10.1	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		ck, White,	
36	s aff	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☒ Divorced	If Yes. G	live		1∐Yes 2⊠No	Specify:		Specif	y:	,
9	hour iural				Dates.	160 Dogg	dent's Usual Occup	untion	14	b. Kind of B	Blac	
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N	ed v fygie her t		12		4		Teache		(Fireh Bainfulle Ba		ducato	Ľ
2	be fil d otl	Be	17. Father's Name (First, Middle,	Last)				18. Mothers Nan	ne (First, Middle, Ma	alderi Surnar	ne)	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Madical Exterior must be notified at	2	Monroe Francis La	ke, Sr.				Leomia El	izabeth Den	nard		
a	2 sho n and is ma rauma		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town	, State, Zip	Code)
	1 and 2 Health em 27 i		Edward M. James,	Sr. / Son		1315	Orvis Stree	et Charl	otte, North	Caroli	na 282	16
ē	oth oth		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	ne)	Date 20	Oc. Location	- City or To	own, State
2	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State	Bazzel C	•		er 9,2009	Buckt	oran M	aryland
		1	21. Signature of Funeral Service	-			enecary 2. Name and Addre		812 Hubb			arytaru
Ba	permit. Departr Importa any Inju		Mast F	Licensee	Ollars.	1						1613
			1 / Ilulue ne	e / pare	veg		oardley Fur		Cambridg		land 2	
			23a. Part 1. Enter the disease, o shock, or heart failure. List	only one cause on	each line.			ng, such as cardia	c or respiratory arres	ST,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		Septi	c SI	OCIC					Oliset and Death
	/Medical		resulting in death)	a	o (or as a conseq							
	Examiner			. /	preun	- Onia						
		er	Sequentially list conditions, if any leading to immediate	Due to	o (or as a conseq	uence of:		1541	. N			
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	11	rihorn	tr	ac/-	IMPEC	Na			
	al-tra	ха	that initiated events resulting in death) Last	C. Due to	o (or as a conseq	uence of):						
8760,	be ( buria	al		•								
87	phys the	dical		d					<del></del> .		_	
9 ×	ertifi Jing e as	Physician/Me	IF FEMALE:	00. 1/								
Box	ath c ttend	an/	23b. Was decedent pregnant in the past 12 months?		utcome of pregna birth 2 🗆 Feta		☐ Ectopic pregnanc	у			ate of deliv onth	ery Day Year
E	he a	sici	1 ☐ Yes 2 ☐ No	4 ☐ Pre	gnant at time of	death 5	Other (specify) _			144	OHH	Day
<u>Ч.</u>	at the by t tach	h	9 Unknown									
Division of Vital Records, P.O.	s the	by P	Part II. Other significant conditi	ions contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use cor	ntribute to t	he cause of death?
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<u>~</u>	t Th	ပိ								₽No	1 ☐ Yes	2 2 NO
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0	ng P Iter t nera	Ë	27. Mann		e of Injury onth, Day, Year)	28b. Time o			28d. Describe how			
<u>ō</u>	ath. r: Ai	aţic		igation				Yes 2 □ No				
<u> </u>	Atte	ific	3 Suicide 6 Could	nined   286. Plac	e of Injury - At h	ome, farm, sti	eet, factory, office		28f. Location (Str	eet and Num	ber or Run	al Route Number,
Ö	al or afte Dir d in	Certification: To	4 Homicide	Bull	ding, etc. ( <i>Speci</i>	·y/			City or Town,	State)		
	spit.		29a. Certifier 1 Certifyl	ng Physician: To ti	ne best of my kn	owledge, deat	h occurred at the ti	ime, date and plac	I e, and due to the ca	use(s) and r	nanner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medica one)	I Examiner: On the	basis of examina	ation and/or in	vestigation, in my	opinion, death occ	urred at the time, da	te and place	, and due t	to the cause(s)
	ithin o the	Me	29b. Signature and title pl certific	A			29c. Licens	se number	29	d. Date sign	ed (Month,	Day, Year)
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	'		30. Name and address of persor	who completed ca		m 23a) (Type,	Print)		18.00 :		1 1	5 // 15
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	Funeral Director		5. Social Security N	080	6. Sex 1 □ M 2 💢		54	la <i>st birthd</i> a Yrs.	Month	der 1 Year ns Days	If Unde Hours	Min.	8. Date of (Month,	Day, Ye
	rland ow		Usual Residence of 10a. State	10b. County			10c. City	y, Town or	Location					
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	th the or 28; e not	Director	10e. Street and Nu	mber					10f.	Zip Code				10g.
	23a ust b		6102 Bre	ezewoo						20770				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Marr 3 Widowed		ed 1 TY	Decedent E d Forces? les 2 X N , Give or Dates:	Ever in U. Io	S. 1		cedent of I pecify Cub 2 X No	Hispanic O an, Mexica Specify		pecify Yes or Rican, etc.)	No-
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2	Pages ent of nt: If I		1 X Burial 2 I 4 ☐ Donation		3 ☐ Removal fr	om State		emetery, c			1	1 O /O	1/2009	Br
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1000	es that the death certificate be executed  Medical  Medical  Great the attending physician and perfached for use as the burial-transit	dical Examiner	Immediate Cause (disease or condition disease or condition resulting in death)  Sequentially list or if any, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death) if	nditions, nmediate rrying injury	b. Due	AFBP e to (or as a e to (or as a	a consequ	uence of): uence of):	nz 6	2,55,	182			
	the death certificaty the attending place as t	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2 9 Unknown	months?	4□P	, outcome ( ive birth regnant at nknown	2 🗌 Feta	death	3 □Ectopio 5 □ Other		у			_
5	quires that the de	þ	Part II. Other signif	ficant condition	ns contributing	to death bu	it not resu	ulting in the	underlyin	g cause giv	en in Part	I.		id tobac □ Yes
	. The law requir cate has been si page 2 should I	Completed												utopsy erformed
	Physician: The this certificate al director, pag	Be (	25. Was case refer examiner?	red to medical	Hannital					1		ce of Deat	th (Check on	ly one)
5	Physical dire	၉	1 ☐ Yes 2 ☑ 27. Mannger of Deat			Inpatie		ER/Outpat		DOA		lursing Ho	ome 5 R	
	ending Ph sath. or: After th he funeral	ation	1 ☑ Natural 2 ☐ Accident	5 Pending investig	ation (/	Month, Day		28b. Time Injun		28c. Inju Wo 1	ry at rk?  Yes 2[	]No	28d. Descrit	e now i
	tal or Attend s after death. al Director: / ed in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6	nod   28e. P	lace of inju uilding, etc	ry - At ho :. (Specif)	me, farm,	street, fac	tory, office			28f. Location City or	n <i>(Str</i> ee Town, S
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical (	29a. Certifier (Check only one)	1 ☐ Certifyin 2 ☐ Medical	g Physician: To Examiner: On the and r	the best one basis of manner sta	examina	wledge, de tion and/or	ath occurr investigat	ed at the ti	me, date a opinion, de	and place eath occu	, and due to t rred at the tir	he caus ne, date
	To th withir To th comp	Me	29b. Signature and						1	29c. Licens				29d.
					- Car					RAS	2,2,5	(		5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

VACKSON

**Physician** 

/Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Day Year 4:45 AM JANNB1-25 2009 4b. City, Town, or Location of Death 4c. County of Death Montgomery Birthplace (State or Foreign Country) ar) <u>55</u> VA 10d. Inside City Limits 1 XYes 2 □ No Citizen of What Country? AZU 14. Race - American Indian, Black, White, etc. Black b. Kind of Business/Industry deral Government den *Sur*na*me*) t ity or Town, State, Zip Code) " WD 50PJ3 . Location - City or Town, State rentwood, MD uneral Services rings, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day co use contribute to the cause of death? 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No No e 6 ☐Other (Specify) injury occurred t and Number or Rural Route Number, se(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 25 MAIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend I tem 5 per FH 6898 10/16/09 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AM David 4:35 Michael Kozak 7,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan 21, 1974 Birthplace (State or Foreign
Country) 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Pennsylvania Months: 1 □ M 2 □ F 35 207-32-3051-02 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinational Language. 2009. 1 XYes 2 □ No Maryland Prince George's Bowie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20715 United States 3116 Teal Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married White itimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) never worked none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard A. Kozak Bernadette Gaul ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4451 SW Hagalpan Street Port St. Lucie, FL 34953 Bernadette Brown - mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 10/8/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Eugeral Service Licenses 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part 1. Enser the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EPTICEMI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: he law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the rector, p.ge 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ASPIRATION 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an SORDEA autopsy performed 2 ANO 1 □ Yes NEUROMUSCU director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D61552 ipleted cause of death (Item 23a) (Type, Print) Luck Rd., Lanham, MD. 20106 30. Name and address of person what Kevin Erfan 8118 Good

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day,

OCI

32. Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year PM **Physician** Michael Keen October 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** A MARY RANGE HERITH CARE Buch If Under 1 Year Birthplace (State or Foreign Country) 7. Age (În yrs. last birthday, **Funeral** Days Hours Min 8/377 1948 ar) Virginia **X**M 2□ F 61 Director 220-52-3843 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modical Evandon" is ust by nathed at 1 ☑ Yes 2 ☐ No Havre de Grace Director Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21078 U.S.A. 528 N. Adams Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or DatesVietnam Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental F Avinell Whitt Virgil David Keen ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 37659 Jonesborough, TN 127 Sarah's Way Shirley Garvey (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If iter any Injury or ott once. 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 10/12/09 West Chester, PA R. A. Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LOWYL Physician Unknowik disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to for as a consequence off requires that the death certificate be executed Exami and burial-tra Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown þ σ. s been signed by should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29c. License number Pennsylvan 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar

Deborah 31. Date filed (Month, Day,

Physicians KEEK,

2XE

Bollock, M.D. VA M Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

DX

VA Maryland Health Care System, Perry Point, MD 21902

09-07910 Traci Kerns

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Rea. No Registrar Time of Death 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 11, 2009 1747 hrs Kerns Medical Examiner Traci Lynn 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany Cumberland 909 Fayette Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreian Months Days Hours Min. Director Jul 15. 1969 Country) MD 283-70-3728 40 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Cumberland 10b. County Allegany 1 X Yes 2 No notified at once. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 909 Favette Street 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes white þ Specify: Yes 2 X No specify: Divorced Yes Give Year Widowed t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner ⋛ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hoppartment of Health and Mental Hygiene. Nurse Home Care 18.Mother's Name (First, Middle, Maiden Surname)
Karen Kerns Evans 17. Father's Name (First, Minusion UNKNOWN Be ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 909 Fayette Street Cumberland MD 21504 19a. Informant's Name/Relationship (Type, Print )
Karen Evans mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 10/13/2 Cresaptown MD Scarpelli Funeral Home, Pl.A. Donation 5 Other Specify: 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21503 Approximate Interval 23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure List only one cause of /Medical Death Volatile fluorocarbon (1,1-)
Due to (or as a consequence of): intoxication Immediate Cause (Final disease or condition resulting in death) .l-Difluoroethane amine Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a, PII, 27, 28a-f, perME, g897, 11/4/09 X UNPENDED attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 ✔ No 9 Unknown a Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✓ No 3 Probably 4 Unknown Methadone use Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has b performed? death? Yes 2 No 1 🗸 Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Division of Vital Other<sub>4</sub> Hospital: Residence 6 🗸 Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 After this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No Natural Pending Fd 10/11/09 Fd 7:40 pm To the Funeral Director: completely filled in by the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 909 Fayette St, Apt. 3, Cumberland, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide (Specify) found at residence Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 12, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

			For State Registrar	State of M	aryland		artment of F rtificate of I		and M		jiene eg. No.	11119	03260
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month Septemb	th Day	Ž009	3. Time of Death 9:50 P M
	/Medic	al	Hsiu-Hung Lu  4a. Facility Name (If not institution, give st	reet and number	}		4b. City, Town, o	r Location o		Septem		y of Death	J.50 I
1	Examin	er	Casey House	reet and name of	,		Rockvil				Montg		
	Funeral		5. Social Security Number 6. Sex	M 2 XF 7. A	ge (In yrs. la		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Count	ace (State or Foreign ry)
	Director		220-72-9285	M ZLAF	75	Yrs.				Jan 12,	1934	China	1
	and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10	d. Inside City Limits
	Mary Lates	ţo	MD Montgomery	У	Beth	nesda							1 □Yes 2 <b>K</b> No
	or 28s	Director	10e. Street and Number				10f. Zip Code				10g. Citizen o	What Count	ry?
	23a c		10250 Westlake Driv				20817				JSA		1.45
	er des items	Funeral	11. Walital Status	2. Was Decedent Armed Forces	?	. 13.	Was Decedent of H If Yes, specify Cub	tispanic Or an, Mexicai	igin? (Spe n, Puerto I	ecify Yes or No- Rican, etc.)		ace - America ack, White, e	
35	Irs aft	by F	1 Never Married 2 Married 3 Vidowed 4 Divorced	1 ∐Yes 2 X If Yes, Give Year or Dates:	1140		1 □Yes 2X No	Specify:			Spec	ify: Asia	an
5	2 hou	ted	15. Decedent's Educ (Specify only highest grade	ation		16a. Dece	dent's Usual Occup	pation	t of worki	na	16b. Kind of	Business/Ind	ustry
Z	ifhin 7 ne. <b>"ran "r</b>	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Homen	kind of work done DO NOT use retire	d)			Own Ho	me	
N	flied within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be multified at		17. Father's Name (First, Middle, Last)			nomen	arei	18. Moth	er's Name	(First, Middle,			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Experimentation and	To Be	Hong Liao Fu					Yuan	Lin				
ary	shoul and M s mari umati	F	19a. Informant's Name/Relationship (Typ	e. Print)	Ų		ng Address (Street						
	1 and 2 Health a em 27 is		Shirley Afable/dau	ghter			Linden						
w	Pages 1 and the lint; If Iten		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Re	emoval from State	3 1		sition (Name of natory or other pla			ate	20c. Location	-	
Ē	t. Pag tment tant;		4 □ Donation 5 □ Other (Specify)		Fina	and the second second	rney Cre				Woodbi		
Ba	permit. Pages Department of Important; If It any Injury or o		21. Signature of Funeral Service Licens	e // H			Name and Addre						
	-		23a. Part 1. Enter the disease, or complic	cations that cause	ed the death.	251 Be Do not en	everly L. ter the mode of dyi	HECK ng, such as	rotte s cardiac d	or respiratory ar	rest,	MITTE	Approximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final			arcino	ma of Un	known	Prin	narv			Onset and Death
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		ledi										- 550	
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	at the dea by the at tached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant 9 □ Unknown		eath 5	Other (specify) _						.,
<u>v.</u>	that the	F.	Part II. Other significant conditions con	tributing to death	but not resu	Iting in the u	nderlying cause gi	ven in Part	1.	23e. Did t	obacco use co	ontribute to t	ne cause of death?
ds,	uires tha signed Id be det	d by								1 🗆 `	Yes 2 □ No	3 ☐ Prot	oably 4 🗆 Unknown
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S	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Ir	njury - At ho	me, farm, st	reet, factory, office	1169 66		28f. Location (	Street and Nu	mber or Run	al Route Number,
<u>&gt;</u>	alor / s after l Dire	Certification: To	4 Homicide determined	building,	etc." (Specify	<i>'</i> )				City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier  (Check only  2 Medical Examin	sician: To the bes	st of my know	wledge, dea	th occurred at the	time, date a	and place,	and due to the	cause(s) and	manner as :	stated. o the cause(s)
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	<b>7</b> ₩ 6 ⊗		29b. Signature and title of certifier  J. 120 uodd	hou,	mD			3 74	8		Septem		
	ζ		30. Name and address of person who co			23a) (Tvne							
			Jocelyne Kouatchou					Rd. R	ockv	ille, M	D 2085	5	
		ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signat	ture							
	Regist	rar	OCT 1 20	1114 1	222.00	M .	BOK						

			For State	State	of Maryla	nd / Depa	artment ( <i>rtificate</i>				giene Reg. No.	HIG	33251
			Registrar  1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea	ath	V	3. Time of Death
	Physicia	an	Sophia Elizabe							Month 0 9	2B	2009	4.45 b. M
	/Medic		4a. Facility Name (If not institution, g		ımber)		4b. City, To	wn, or Loca	ation of Death		-	nty of Death	
	Examin	er	Kensington Nurs				Ke	nsing	ton		M	ontgon	ery
	Funeral		<u> </u>	Sex		s. last birthday)	If Under 1		ours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth	place (State or Foreign ntry)
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with t	aor	<u> </u>	3001 McComas Ave	nuo				20895			Unit	ed St	ates
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Maryland d 2 should be file	marked	မ			-	10h Maili	na Address (f	Street and I		al Route Numb		wn. State. Zi	ip Code)
12 st	e s	iá (r)	19a. Informant's Name/Relationship Angela Thompson		er					inton,		0735	
	Heal		20a. Method of Disposition			o. Place of Dispo cemetery, cre			Octo			on - City or T	own, State
mor Pages	nt of it		1 XBurial 2 ☐ Cremation 3		n State	cemetery, cre [armony				oer 2009	Land	01/0°C	Maryland
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<b>Dalt</b>	Department of I Important: If ite any injury or of once.		John (	A town	nt 7	. 1			g Rd. N		ningtor		20019
			23a. Part1. Enter the disease, or co	omplications that	caused the de	7/					arrest,		Approximate Interval Between
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	ling p e as t	Mec	IF FEMALE:	00 11							00.1	D. 1 f . d. 12	
<b>box</b>	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 mounths?	1 ☐ Liv	utcome of pre e birth 2 - F	etal death 3	☐ Ectopic pre				23d.	Date of deli Month	Day Year
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J. #	ed by Jetac		Part II. Other significant condition	s contributing to	death but not	resulting in the	underlying car	use given ir	n Part I.	23e. Did	tobacco use	ntribute to	the cause of death?
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<u>_</u> _	ficate n, pa		25. Was case referred to medical	my				26	Place of Dea	1 ☐ Yes th (Check only		1 □Yes	2 □ No
Sicia	cert	Be C	examiner?	Hospital:	☐ Inpatient 2	 2 ☐ ER/Outpatie	ent 3 🗆 DOA	Othor	1	ome 5 ☐ Re		Other (Spe	cify)
<b>o</b> ₫	er this	۳	27. Mapher of Death		te of Injury onth, Day, Year			Bc. Injury at Work?		28d. Describe			
DIVISION Of VITAI Mecords,	death. tor: After thi the funeral o	Ę.	Natural 5 Pending 2 Accident investiga		упин, Бау, теан	// Injury	M		2 □ No				
VIS	after death Director: In by the	iji	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Fla	ce of Injury - A	At home, farm, s	treet, factory,	office		28f. Location City or To	(Street and Nown, State)	umber or Ru	ıral Route Number,
	al Dir ed in	Certification: To	. /										
joso	within 24 hours after d  To the Funeral Direct completely filled in by		29a. Certifier  (Check only 2 Medical E	Physician: To t xaminer: On the	he best of my basis of exan	knowledge, dea	ath occurred a investigation,	at the time, in my opini	date and place ion, death occu	e, and due to thurred at the time	e cause(s) ar e, date and pla	id manner a ace, and due	s stated. e to the cause(s)
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0	3		30. Name and address of person w	hocompleted ca	use of death (	(Item 23a) (Type	or ele	MA	OSER	000		180	per That
16			31. Date filed (Month, Day, Year)	30	Registrar's Si			///	- "	-036			
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			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment ertificate			Mental Hy	/giene Reg. No.		33262
			1. Decedent's Name (First, Middle, Last	1)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physici /Medio		Mary Kathryn						Septem	ber 2	27, 2009	3:00 p M
	Examir	ner	4a. Facility Name (If not institution, give 32 Chase Street			W	estmi	ation of Death			Carro	011
ı	Funeral Director		217-10-7502	7. Ag □ M 2 <b>/3</b> F	e (In yrs. last birthday 89 Yrs.	Months		Under 24 Hrs. Iours Min.	8. Date of B (Month, D	ay, Year)	Cot	place (State or Foreign intry) yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	Mary B-f sh	ctor	Maryland Carrol	.1			Wes	stminst	er			1 XYes 2 No
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner rust be notified at	Funeral Director	10e. Street and Number 32 Chase Street			10f. Zip C	ode	21157		10g. Citi	zen of What Cou USA	intry?
	ems 2	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	Was Deceder	nt of Hispa Cuhan, M	nic Origin? (S	pecify Yes or N o Rican, etc.)	0-	14. Race - Amer Black, White	
980	ours after ral", or ite Evernine	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 🚓 🛣 <del>Di</del> vorced	1 ∐Yes 2 1 If Yes, Give Year or Dates:	No	1 ☐ Yes 2		pecify:	5 Tilodii, 500.)			ite
5-0	72 hc "natu	letec	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dec	edent's Usual e kind of work	Occupation done durin	n ng most of worl	king	16b. Kii	nd of Business/l	ndustry
21215-0036	ed within /giene. er than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5	14)	on NOT use mstres	s				lothing	
Maryland	uld be filk Mental Hy irked oth tic event	To Be	17. Father's Name (First, Middle, Last)  Jesse Black				18.		ne (First, Middle e Harba		Surname)	
	nd 2 sho alth and I 27 Is ma ar trauma		19a. Informant's Name/Relationship (7) Mary-Ellen R. Schu								r Town, State, Z FL 3278	
Baltimore,	ages 1 a ent of He nt: If item y or othe		20a. Method of Disposition  1		20b. Place of Disp cemetery, cre Germantov	osition (Name matory or other vn Beth	of er place)	9/30	Date /2009		cation - City or T	
Baltir	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens		2	of God 22. Name and 91 Wil	Address of	f Facility	Myers-D	urbor	·	ral Home
			23a. Par 1. Enter the disease, or comp	lications that caused	the death. Do not er						,	Approximate Interval Between
- Andrews	Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Mul	ti urgan	Sui	lura	<u>,                                      </u>				Onset and Death
٦	Examiner			Due to (or as	a consequence of):							
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):							
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):							
8760,	e be e sician buria	dical E		d	a consequence er,							
9	tificat ig phy as the	ledic		u								
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after cleath. within 24 hours after cleath. to the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pre ☐ Other (spec				2	23d. Date of deli Month	very Day Year
	res that i signed by be deta		Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cau	se given in	Part I.				the cause of death?
COLC	w require s been sig should b	eted							24a. Wa			topsy findings available
Division of Vital Records,	: The law icate has t page 2 s	Completed by							auto	opsy form <u>ed</u> ?	prior to death?	ompletion of cause of
Vit.	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor:		th (Check only			
of	ding Phys th. After this funeral dir	<u>ا</u>	1 ☐ Yes 2 M No	28a, Date of Inju	ent 2 ER/Outpatie		: Injury at Work?	4 ☐ Nursing H	ome 5 Res 28d. Describe		Other (Spec	cify)
ion	ath. rr: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y, Ye <i>ar)</i> Injury	м		2 □ No				
Divis	al or Attend s after death Il Director: /	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc.	ury - At home, farm, si c. (Specify)	reet, factory, o	office	_	28f. Location City or To	(Street and wn, State)	d Number or Ru )	ral Route Number,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best iner: On the basis o and manner sta	of my knowledge, dea f examination and/or i ated.	th occurred at nvestigation, in	the time, on my opinion	date and place on, death occu	e, and due to th	e cause(s) e, date and	and manner as I place, and due	stated. to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	,		29c. I	lcense nui	mber		29d. Dat	e signed (Month	i, Day, Year)
	0		1 Myselfs			1	133	200		9	128/0	5
W	14/10		30. Name and address of person who constructions of the state of the s	ompleted cause of d	eath (Item 23a) (Type		L CEN	7122	912 WA	SHING	TON RE	57
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	barker	,					

· DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1:15 AM 09 -30 -Patricia Lewis 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salis bur Wicomico Hospice at the -oastal Lake If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F 72 Director 10-9-1936 Maryland 214-34-7312 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County the marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "edical Examination in difficult at 1 ☐ Yes 2X No Director Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6118 Jack Drive 21804 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify. White If Yes. Give þ 3 ☐ Widowed 4 🂢 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth ပ Parker Atwood, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Pledger - Daughter 26965 Pratt Road, Salisbury, Maryland 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-30-2009 | Delmar, Delaware Crematory of Delmarva: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Whene 705 E. Main Street, Salisbury, Maryland 23a. Paxt. Enter the disease, or over lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List, any one cause on each line. Immediate Cause (Finel **Physician** CANCPIA LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carrier of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknowh 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 □Yes 2 🖼 🕏 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence Dother (Specify) HOSPICAL 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Peath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058410

Registrar DHMH 17 Rev 1/2001

State

e Hungan 31. Date filed (Month, Day, Year)

OCT 01

Division of Vital Records, P.O. Box 68760,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		State Registrar	Cer	rtificate of Death		Reg. No.	3325;
					Month	ath Day Year A A A A A A	3. Time of Death
		4a. Facility Name (If not institution, give street and number)					h
					24 Hrs   e Data of Rin		
Funeral Director		219–36–6127	69 Yrs.	Months Days Hours	Min. (Month, Da July 5	y, Year) Co , 1940 Mai	hplace (State or Foreign untry) cyland
Maryland a-f show	tor	10a. State 10b. County 10b. County 10chester	10c. City, Town or Lo		2		10d. Inside City Limits 1 <b>½</b> Yes 2 ☐ No
h with the		10e. Street and Number 1004 Glasgow Street		10f. Zip Code MD		10g. Citizen of What Co USA	untry?
urs after deat al", or items 2	by	Armed Forces?	0			Black, Whit	e, etc.
- 3	pleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-1)	(Give	kind of work done during mod DO NOT use retired)	st of working		
	Con	12 4	<u></u>				ing
be de eve	Be	17. Father's Name (First, Middle, Last)  Thomas H. Maguire Jr.		1			
nd 2 shou alth and N 27 is ma r trauma		19a. Informant's Name/Relationship (Type. Print)  Louise Maguire wife	I	•			Zip Code)
Pages nent o ant; If		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crer	natory or other place)	Date 10/7/09	_	
permit. Departr Importa any Inja once.		21. Signature of Funeral Service Licensee			THOMAS I		
Physician /Medical Examiner	ner	shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a	a consequence of):	5			Approximate Intervat Between Onset and Death
ifficate be execute g physician and as the burial-transi	edical	that initiated events	consequence of):				
the death ceri y the attendin ched for use	ıysician/M	23b. was decedent pregnant 1 Live birth	2 ☐ Fetal death 3 ☐			23d. Date of de Month	elivery Day Year
quires that n signed b	þ	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in Part			o the cause of death?
The ate h		25. Was case referred to medical		26 Dla	auto perf 1 □ Yes	prior to death? 2 □ 1 □ Ye	
		eyaminer?		20.1100		2110)	
yslcl s cer			nt 2 ER/Outpatie	nt 3 DOA Other: 4 D		idence 6 ☐Other (Sp	ecify)
ng Phys fter this meral di	မ	1 Yes 2 No Hospital 1 Inpatie  27. Manner of Death 1 Natural 5 Pending (Month, Day		of 28c. Injury at Work?	lursing Home 5 Res	idence 6 Other (Sp how injury occurred	ecify)
ng Phys fter this meral di	မ	1 Yes 2 No Hospital Inpatie  27. Manner of Death 1 Natural 5 Pending investigation investigation 2 Accident investigation	ry 28b. Time o Injury	of 28c. Injury at Work?  M 1 Yes 2	lursing Home 5 Res		
ng Phys fter this meral di	Certification: To	27. Manner of Leath   Shatural   5   Pending	ry, (Year) 28b. Time o Injury  At home, farm, str., (Specify)  of my knowledge, deat examination and/or ir	of 28c. Injury at Work?  M 1 Yes 2 Freet, factory, office	Residence   28d. Describe   28d. Describe   28f. Location   2	how injury occurred  (Street and Number or Fivn, State) e cause(s) and manner	lural Route Number, as stated.
Attending Physic death. ector: After this by the funeral dis	မ	27. Manner of Death   Natural   Suicide   A Could not be determined   28a. Date of Injur (Month, Day investigation   28b. Place of Injur (Month, Day investigation   28c. Plac	ry, (Year)  28b. Time of Injury  At home, farm, str., (Specify)  of my knowledge, deat a examination and/or inted.	at 28c. Injury at Work?  M 28c. Injury at Work?  M 1 Yes 2 Cereet, factory, office  th occurred at the time, date hyestigation, in my opinion, do  29c. License number	28d. Describe 28d. Describe 28f. Location City or To and place, and due to the path occurred at the time	how injury occurred  (Street and Number or Fiven, State)  e cause(s) and manner or date and place, and du  29d. Date signed (Mor	iural Route Number, as stated. e to the cause(s)
ng Phys fter this meral di	Certification: To	27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injur (Month, Day investigation of Death of Death investigation of Death	ry, (Year)  28b. Time of Injury  At home, farm, str., (Specify)  of my knowledge, deat a examination and/or inted.	The state of the occurred at the time, date on the occurred at the occurred at the time, date on the occurred at the	28d. Describe 28d. Describe 28f. Location City or To and place, and due to the path occurred at the time	how injury occurred  (Street and Number or Fiven, State)  e cause(s) and manner or date and place, and du  29d. Date signed (Mor	iural Route Number, as stated. e to the cause(s)
	The law requires that the death certificate be executed THE parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Law requires that the death of the attending physician and any injury or other traumatic event, it. I write I level that the law read of the attending physician and any injury or other traumatic event, it. I write I level that any injury or other traumatic event and it. I level that any injury or other traumatic event and it. I level that any injury or other traumatic event and it. I level that any injury or other traumatic event any injury or other traumatic event and it. I level that any injury or other traumatic event any injury or other traumatic event and it. I level that any injury or other traumatic event and it. I level that any injury or other traumatic event and it. I level that any injury or other trauma	The law requires that the death certificate be executed to be exec	Thomas Henry Maguire II	1. Decedent's Name (First, Middle, Last)	Physician Medical Examiner    Second Security Number   1.0 percent   1.0	Physician   Medical Parameter   December Name (First, Middle, Last)   Physician   Medical Parameter   December Name (First, Middle, Last)   Physician   Medical Parameter   December Name (First, Middle, Last)   Physician   Name of the Institution, give street and number)   As. Facility Name of the Institution, give street and number)   As. Facility Name of the Institution of Name of the Institution of Name of	Thomas Henry Maguire III  Accounting the physician (Print, Middle, Last)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Examiner  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Accounting the physician (Middle)  Thomas Henry Maguire IIII  Thomas He

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		For State	State of	f Maryland		rtment of F		Mental Hygi	ene g. No. 2005	3326
		Registrar  1. Decedent's Name (First, Middle	, Last)		11			2. Date of Death	/	3. Time of Death
Physicia /Medica		PARTHENIA		/-	110R-	TON		49nth/2	7 2009	1244 AM
Examine		4a. Facility Name (If not institution	4 /	SPITAL		4b. City, Town, o	Location of Death	16701	4c County of Death	EORGES
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
Director		5 78 99 6357 Usual Residence of Decedent	1□M 2 <b>/</b> F	90	Yrs.	MIOTILITS Days	Plodis Will.	4-19-1	919 VIK	GINIA
yland now		10a. State 10b. County	)	10c. City,	Town or Loc	cation				10d. Inside City Limits
e Mar	cto	MO P.G.		10	VITI	and				1 XYes 2 □ No
death with the Maryland ms 23a or 28a-f show rmst be roffled #1		10e. Street and Number	200 /00	10 #42	2	10f. Zip Code	460	10	g. Citizen of What Cou	intry?
after death with the Marylan or items 23a or 28a-f show mirer reast be rediffied at	Funeral Director	11. Marital Status	Armed For	dent Ever in U.S	. 13. V	Vas Decedent of H	lispanic Orlgin? (S an, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White.	
s after	by Fu	1 XNever Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced		2 No ∕e No		□Yes 2XNo	Specify:		Specify:	ack
2 hour		15. Decedent	t's Education	ates.		lent's Usual Occup	oation during most of wor		6b. Kind of Business/I	ndustry
vithin 7	Completed	(Specify only highes	College (1	-4or 5+)	Viife. E	NOT use retire	d)		Home M	Taker
I Hygie other t	Be င	17. Father's Name (First, Middle,			<u></u>	100		ne (First, Middle, M	,	
2 should be filed within 72 hours after nand Mental Hyglene. is marked other than "natural", or ite raumatic event, it a l'acel Emmira	으	ARTHUR	/	TON			ROSI	A WHI	TR	
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, if a livering in the months.		19a. Informant's Name/Relations			19b. Mailin	g Address (Street	and Number or Ru	iral Route Number, $\sqrt{H42Z}$ ,	Suit land	MD 20746
of Health of Health item 27 r other to		20a. Method of Disposition		20b. Pla	metery, cren	sition (Name of natory or other pla	ce)		Oc. Location - City or T	own, State
Ement of tant: If its tant: If its jury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	State Liv		Memori		109 -	JuiT land	(,MD
permit. Departr Importa any inju		21. Signature of Funeral Service	Licensee	,	22	Name and Address	ess of Facility	al Home	420 H ST.	C. 2000Z
		23a Part I Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death.	. Do not ente	, , , , , ,			st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	_a. RAF	DID A	tria	1 Fibr	es/latio	CAC		Onset and Death
/Medical Examiner		rosuling in dealing	Due to (	or as a conseque	ence of):  MYO	CARDI	AL JUNT	Faretic	(A,	
p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseque	ence of):					
be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque	ence of):					
	dical		d							
	Med	IF FEMALE:	22a If year out	come of pregnar	201					
death certific e attending p d for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live t 4 ☐ Pregr	birth 2 🗖 Fetal nant at time of de	death 3	Ectopic pregnand Other (specify) _	СУ		23d. Date of deli Month	very Day Year
at the de	Phys	9 Unknown	9 □ Unkn					OO- Did tob	use sentribute to	the equipp of death?
signed d be det		Part II. Other significant condition	ns contributing to de	eath but not resul	iting in the ur	nderlying cause gi	en in Part I.		acco use contribute to s 2	obably 4 Unknown
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scertificate has the law inector, page 2 s	Com							autopsy perform 1 ∐Yes 2	ned? death?	completion of cause of 2  No
sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		fn:0 : ::	Oth	oer.	ath (Check only one		
ding Phys h. After this funeral dir	ا: T	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 2 for the contract of Injury th, Day, Year)	28b. Time of Injury	I 3 L DOA	ry at	28d. Describe ho	nce 6 ☐ Other (Spec w injury occurred	city)
tendin leath. tor: Af the fur	catio	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation			M 1 [	Yes 2□No	Cof Landing (C)		
after d after d Direct d in by	Certification: To	4 Homicide determ	.:	ng, etc. (Specify	me, tarm, stre	eet, factory, office		City or Town	reet and Number or Ru , State)	irai Houte Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ical C	(Check only 2 Medical	Examiner: On the b	asis of examinat	vledge, death	n occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
o the l	Medical	one) 29b. Signature and title	and man	ner stated.		29c. Licen	se number	29	9d. Date signed (Mont	n, Day, Year)
F > F 0		) Cac	L	) 		D'	12955		9/29/2	2009
22		30. Name and address of person	who completed cause	se o death (Item	23a) (Type,	Print) /ini	ACSTON.	Rd. Sta	207 MD	WASH. 20744
Stat		31. Date filed (Month, Day, Year)		Registrar's Signati	21			7 0000		
Registra	ır	OCT 0 5 2009	cenera!	g. par	1000					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Helen Manning 433 potember 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Doctors Community Hospital Lanham Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F 219-96-5176 12/26/80 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Landover Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3239 75th Avenue United States 20785 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No African Specify Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunication Specialist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Lee Wyche Barbara Anne Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Brown/ Sister 3829 1st Street SE Washington, DC 20032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 0 Lee's Crematory 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 2009 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Rd. NE Washington, DC 23a. Par 1 / Inter the disease, or complications that show, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and Death Immediate Cause (Final disease or condition resulting in death) ice of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 5 ☐ Other (specify)

**Physician** -/Medical Examiner

Physician

Examiner

Directo

Funeral

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Completed

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10a, State

**Funeral** 

Director

be filed within 72 hours after death with the Maryland ntal Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marklan Evantment must be notified at

Maryland 21215-0036

Baltimore,

/Medical

Examine

	nd.	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
	To the Funeral Director: After this certificate has been signed by the attending physician and	urial-	
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within 24 hours after death.	70 ₩	comp	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnar 1  □ Live birth 2  □ Fetal· 4  □ Pregnant at time of de 9  □ Unknown	death 3 ☐ Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resul	ting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1   Yes 2   100	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 🗆	DOA Other: 4 In Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner f Death  Natural 5 Pending 2 Accident investigation	(Month, Day, Year) on	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	
3 ☐ Suicide 6 ☐ Could not lead to determine d		ne, farm, street, fact	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

State

OCT 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MCGREEUY DANIEL 4:30 AM OCTOBER 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign
 Country) **Funeral** 1 M 2 | F 213.70-1804 Director -12-56 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location show 1 Yes 2 No notified Director MD. 28a-f 10e. Street and Number 10g. Citizen of What Country? must be 4311 ROBERTON 21206 or items 23a .5.A Funeral within 72 hours after death Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married Specify: Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation Injury or other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRI marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If item 27 Is marked o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawkeect, Apr. 302 BALTIMORE MD-21234
Disposition (Name of Date 20c. Location - City or Town, State 3altimore, Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 remation 3 Removal from State 5 Other (Specify) CREMATORY 10-8-09 4 Donation ODENTON MD. 21. Signature of Fu 22. Name and Address of Facility Daugherty Funeral Hone any 260 (MOUNTAIN RD. PASADEN4, M.D. 21122 Enter the disease or aused the death. Do not enter the mode of dying, such as cardiac or respirator comp Approximate shock, or heart failure. List only of se on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death SUBDURAL **Physician** HEMORRHAGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown P0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 2 ☐ No 3 ☐ Probably 1 Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: has 2 No 1 🗌 Yes 2 🗌 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA ည funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Director: After Pending investigation Injury 1 🗌 Yes 2 No 2 Accident hours after death. Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide the Hospital To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29c. License number 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) RES-000 OCTOBER 7

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIM

600 North Wolfe St, Baltimore, MD, 21287

ORIGINAL

36

		Please	Type or Print					-		•			
		For State Registrar	State of Mar	-		nent of F cate of		-	giene Reg. No.	2009	33268		
Physicia	an	Decedent's Name (First, Middle, La     Mack Nouraee	st)					2. Date of De Month Septem		Year	3. Time of Death		
/Medic	al	4a. Facility Name (If not institution, give	ve street and number)		4h	City Town o	r Location of Death	Septem		28, 2009 County of Death			
Examin	er	8531 Plum Creek I				aither				ntgomery			
Funeral		5. Social Security Number 6. 8		(In yrs. last birti	hday) If U	nder 1 Year		8. Date of Bir (Month, Da		9. Birth	nplace (State or Foreign untry)		
Director		579-64-4607 Usual Residence of Decedent	I AN ZUF	69	rs.			July 2		940 Iran	1		
yland		10a. State 10b. County	1	Oc. City, Town	or Location						10d. Inside City Limits		
the Maryland r 28a-f show notified at	ctor	MD Montgome	ery	Gaither	sburg						1 XYes 2 ☐ No		
or 28	Director	10e. Street and Number				f. Zip Code			_	zen of What Cou	untry?		
sath wi	Funeral	8531 Plum Creek I	I 12. Was Decedent Ev	orio II C		0882	Jianania Origin? (Sn		USA	14 Page Amer	ioan Indian		
fter dear r items	Fun	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?	er in U.S.			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	,-				
ral", o	δ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Y€	es 2XINo	Specify:			Specify: Wh	ite		
filed within 72 hours after death with the Maryland Hyglene. vther than "natural", or items 23a or 28a-f show ent, the modical Examinat must be notified at	Completed	15. Decedent's E	ducation ade completed)	16a.	(Give kind o	Usual Occup of work done	during most of work	ing	16b. Ki	nd of Business/I	ndustry		
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uld be Vienta Irked Itic ev	To B	Yusef Nouraee					Behjat M	loyedi					
2 sho and I is ma		19a. Informant's Name/Relationship									ip Code)		
1 and Health em 27 ther t		Andisheh Nouraee	5011	20b. Place of				Date			Town State		
permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examination.		20a. Method of Disposition  1 ☐ Burial 2 【Cremation 3 ☐		cemeter	v, crematory	or other pla	matory 09			•			
nit. Partme ortan injur.	П	4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice)		TINGT ,	_								
permi Depar Impor any ir		Bever LH	a little	MO125	1Bever	g nome rlv L.	Heckrott	e. P.A.	Cla	rksville	e, MD 21029		
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the								Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition resulting in death)  Small Cell Cancer of Lung  Due to (or as a consequence of):											
/Medical Examiner		resulting in death)  Due to (or as a consequence of):											
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
executed an and rial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	C										
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eath certificate be attending physicia for use as the bur	Physician/Medical	IF FEMALE:	23c. If yes, outcome of	pregnancy					Specify: White  16b. Kind of Business/Industry  Auto Dealer  ddle, Maiden Surname)  umber, City or Town, State, Zip Code) ter, GA 30030  20c. Location - City or Town, State  9 Woodbine, MD  vice P.O. Box 784  A. Clarksville, MD 21029  Approximate Interval Between Onset and Death 9 months  23d. Date of delivery Month Day Year  Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4X Unknown				
death e attel d for L	iciar	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti			pic pregnancer (specify) _	су				*		
at the by th	hys	9 🗆 Unknown	9 🗆 Unknown					-					
res tha	ğ	Part II. Other significant conditions of Hyponatremia	contributing to death but	not resulting in	the underlyi	ing cause giv	en in Part I.						
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e law has b	Completed	Hypertension——		-				24a. Was auto	psv	prior to c	topsy findings available completion of cause of		
ifficate or, pag		25. Was case referred to medical	<u> </u>				OC Place of Door	perfo 1 ☐ Yes		1 ☐ Yes	2 □ No		
ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 💆 No	Hospital: 1 ☐ Inpatient	2 🗌 ER/Out	patient 3 [	DOA Oth	26. Place of Deat			6 ☐ Other (Spec	cify)		
ding Physician: The In. After this certificate ha funeral director, page	L	27. Manner of Death 1 ⚠ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, )	(ear) 28b. T	ime of jury	28c. Inju		28d. Describe		<del></del>			
tendile eath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not b	n		M	1 🗆	lYes 2 □No						
or At after c Direct in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	- At home, far (Specify)	m, street, fa	ctory, office		28f. Location ( City or To	Street an wn, State	d Number or Ru )	ral Route Number,		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur		29a. Certifier 1 Certifying Pl	nysician: To the best of	my knowledge	death occu	irred at the ti	ime, date and place	, and due to the	cause(s	) and manner as	stated.		
n 24 h	Medical	(Check only 2 Medical Examone)	miner: On the basis of e and manner state	xamination and	d/or investig	ation, in my	opinion, death occur	rred at the time,	date and	d place, and due	to the cause(s)		
To the To the Comp	ž	29b. Signature and title of certifier				29c. Licens	se number		29d. Da	te signed (Month	n, Day, Year)		

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel Kalman, M.D. 1396 Piccard Drive Rockville, MD 20850 1 2009

D20367

September 29, 2009

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a-,25,27,28a-f, permE, g896 10/23/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ELECTA L. PHILLIPS 28200 Septemb Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ospital at al emoria astor Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X F Hours Min. oct. 11, 1934 Director 226-42-9266 74 Yrs WASHINGTON, D.C. Usual Residence of Decedent show at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits traumatic event, the Medical Examiner must be notified 28a-f MARYLAND TALBOT OXFORD 1 Yes 2 X No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4524 BACHELORS POINT COURT 21654 UNITED STATES than "natural", or items 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN FRANKLIN LARCOMBE ELECTA ALICE WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4524 BACHELORS POINT COURT, OXFORD, MD 21654 WALTER LEE PHILLIPS/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OXFORD CEMETERY 2009 OXFORD, MD 21, Signature of Funeral Service I cens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) ATHERO ICHAOTIC Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran CERTIFICAT Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? Month ☐ Pregnant at time of death☐ Unknown Dav Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was autopsy performed?

Ves 2 No page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred of a car struck 5  $\square$  Pending injury Naimal work?
1 ☐ Yes 2 X No X Accident 9/8/2009 3:45 p M Investigation utility pole Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Numb City or Town, State) Oxford Road ne Larleigh Ln. Oxford, MD determined near Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 only one) Certifying Nurse Praction ... to the best of my knowled d at the time, detailed plans, and due to the crows also on 3 in or may on efective 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUDWIG ÆGLSEDER/III, MD, 503 CYNWOOD DRIVE, EASTON, MD 21601 Date filed (Month, Day, Year) State . Registrar's Signati Registrar

3

09-07620 Jack Daniel Perkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State			Cert	ificate of	Death	7			R	eg. No.				
Physicia		Registrar  1. Decedent's Name (First, Middle	e,Last)	-						2	Date of Dea	ith	Voca	3	3. Time of Death	$\Box$
dical Examir		Jack Daniel	Perkins								Month Septembe	Day er 30,	2009 2009		1705 hrs	_ 1
6		4a. Facility Name (if not institution		number)		1	4b. City, To	own, or Lo	cation of I			4c	. County of			
#P[7		424 Indiana Avenue					Hager	stown					Vashingt			1
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. las	it birthday)	If Under	r 1 Year	If Under 2	24Hrs.	8. Date of Bi	rth(MM/	DD/YYYY)	9. Birth	place (State or For ntry) <b>Florid</b> a	eign
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or 28	Director	424 Indiana Ave	nue				217	40			İ	US	SΔ			
death with the Maryland or items 23a or 28a-f show must be notified at once.	eral	11. Marital Status		Decedent	Ever in U.S	13 Wa			nic Origin	? (Spe	cify Yes or N			Americ	an Indian, Black,	$\dashv$
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ter de	Ψ.	3 Widowed 4 Div	1 Ye orced If Yes, Give		X No	1	Yes 2	X No	specify:				Specify:	Whi	te	
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2 hor	je	Elementary/Secondary (0-12)		e (1-4 or		during m	nost of work	king life. D	O NOT us	se retire	d)	i				- 1
hin 7 than than	ompleted	12				Mechar	nic					Αυ	itomok	oile		
d wi	Con	17. Father's Name (First, Middle,	Last)			<del></del>		18	3.Mother's	Name (	First, Middle,	Maiden	Surname)			
215 be file stal H ked o	Be (	Michael Dougla	as Perk	ins				]	Debra	ı Je	ean A	rmst	rong			j
21 buld h I Mer i mar	2	19a. Informant's Name/Relations	hip (Type, Print)				-				ıral Route Nu					- 4
MD 12 sh th and 27 is umat		Debra J. Perkin	ns (Mot	her)		424 II	ndian	a Av	enue	Hage	_					
Heal		20a. Method of Disposition		0.		lace of Disporematory or of			etery,		Date	20c.	Location -	City or T	own, State	
ages ant of nt: In		1 Burial 2 X Cremation		al from St	are I	thsbur			ry	Oct.	.5,200	9 Sm	ithsb	urg.	Marylan	ıd
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other St											_		cocheague	-
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Physician	_	25a. Part I. Enter the disease, or	complications the	at caused	the death.	Do not enter t	the mode o	of dying, s	uch as car	rdiac or	respiratory a	rrest, sh	ock, or hea	rt	Approximate Inte Between Onset	
/Medical		failure. List only one cause Immediate Cause (Final disease	0	Gunsh	ot Wound	d of Head									Death	3110
<sub>≫</sub> Examiner		or condition resulting in death)			equence of											
		Sequentially list conditions,	b													
	Examiner	if any, leading to immediate eause. Enter Underlying Cause		as a cons	equence of	):										
	am	(Disease or injury that initiated events resulting in death) Last	Due to (or a	as a cons	equence of	):										
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1 of Vital Records, ling Physician: The law require After this certificate has been si funeral director, page 2 should t	ı.	27. Manner of Death	28a. D	ate of Inj lonth, Day, ND:	ury Year)	28b. Time of	Injury :	28c. Injur	at Work?		28d. Describ Subject sh			ed		
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Division tal or Attendius after death.	ertification					me, farm, stre	eet, factory	, office bu	ilding, etc		28f. Location or Town		and Number	er or Ru	rai Route Number,	City
Division Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	erti	4 Homicide dete		cify) Sii	ngle Fam	ily Home				4	124 Indiana	Avenu	e, Hagers	town, I	MD	
Hosp 24 ho Fund tely f	alc	29a. Certifier 1 Certifying P	hysician: To the	best of n	ny knowledo	ge, death occu	urred at the	time, da	e and plac	ce, and	due to the ca	use(s) a	and manner	as state	ed.	
Division of Vital Records, P.O. Box 68760,  To the Haspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director.	Medical	one) 2 Medical Exa	miner:On the ba		mination ar	nd/or investiga	ation, in my	y opinion,	death occ	urred at	the time, da					
F % F 8	Me	29b. Signature and title of certifi					290	c. License					_		nth, Day, Year)	
		(due) 2						O.C.N	⁄I.Ε.			Oc	tober 1,	2009		
		30. Name and address of persor	n who completed	cause of												
1-1			sistant Medic	al Exar	miner	111 Penn	Street, E	Baltimo	re, MD	21201						
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Pagic																

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 28, **Physician** 2009 Lovealine Lorayne Cooper Phillips 3:40 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 420 5th Avenue Brunswick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 □XF Months Days Hours Min. 212-24-3430 Director 81 May 9, 1928 Maryland Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28e-f show dref must be notified at 10d. Inside City Limits 1X Yes 2 □ No Director MD Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 420 5th Avenue 21716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 🗓 No item 27 is marked other than "natural", o other treumatic event, It e Madical Extern Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lester Irvin Cooper Della Pearl King ပ 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Lynn Jones/daughter 4406 Canton Avenue Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 09/30/09 Woodbine, MD 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** o Coroli /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner insequence of) requires that the death certificate be executed the attending physician and ned for use as the burial-transit resulting in death) Last Due to (oras a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Dav signed by the a 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ shvillahin 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 X No 1 Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manyrer of Death After t Certification; 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 29c. License number 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Christopher Fleming, M.D.

31. Date filed (Month, Day, Year)

610 9th Aus

32. Registrar's Signature

Brunswick, MD 21716

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:56 am 10/1/2009 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hopsital Olney Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🕱 F Months Days Hours Min. 577-86-9245 49 DistrictofCol 11/7/1959 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. 1 ☐ Yes 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 2505-B McVeary Ct. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**½** No 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Program Specialist State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Pendergraph Helena Pendergraph 19a. Informant's Name/Relationship (Type. Print) sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pendergraph-Liggens 710 Bonini Rd. SE Wash. DC 20032 Michelle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 10/6/09 Suitland, Md. 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Service 411 Kennedy St., NW Washington, DC 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypo aly co Due to (or as a consequence of): alycemia disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypomagnese Due to (oxas a consequence o): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day □Yes 2 No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □ Yes 2 □ No 2 🔣 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Impatient

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Positive Examble or mast burn citined at

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Examine Physician/Medical use as the

burial-tran and attending physician for 1 detached ģ signed page 2 should has certificate this

The law requires that the death certificate be executed funeral After death.

Division of Vital Records, Hospital or Attending Physician: ithin 24 hours after death.

o the Funeral Director: A completely filled in by the fu within To the State

þ Completed Be Certification: To 3 Suicide 4 Homicide Medical 29a. Certifier

<u>Padmaja Bandi,</u> OCT 0 5 2009 Registrar

(Check only one)

25. Was case referre	ed to medical		
examiner? 1 ☐ Yes 2 ☐	lo	Hospital:	
7. Manner of Death		28a. [	
1X Natural 2 ☐ Accident	5 ☐ Pending investigation	n (	1

6 Could not be determined

Date of Injury Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated P defining ringsteam: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	
1 Vac	
00.11	_

29c. License number D0068026

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

18101 Prince Philip Dr., Olney, MD 20832 32. Registrar's

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maggie V. Parham 10:5UA.M September 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Days Months Hours Eä Yrs **Director** 229-30-2987 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at **Funeral Director** 10d. Inside City Limits 28a-f 1 X Yes 2 □ No MD Prince George's Upper Marlboro 10e Street and Number 10g. Citizen of What Country? ral", or items 23a o Examiner must be 4502 Exmoore Court 20772 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Black Specify: 3 X Widowed 4 □ Divorced "natural" the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 75 Food Server Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hi fitem 27 is marked ot r other traumatic even ပ Isaac Vines Georgian Vines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4502 Exmoore Ct., Upper Marlboro, MD 20772 Lawrence Parham, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 70/06/5004 Cheltenham, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Strickland Funeral Services Duellar 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Hypoxic Due to Gras a consequence of): disease or condition resulting in death) 41Kmour Medical Examiner Cerebrovascular Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No Month Dav Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed this certificate 1 ☐ Yes 2 🔀 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 🗀 Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury e Hospital or Attending Pt 124 hours after death. e Funeral Director; After th 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 2 Accident 3 Suicide 4 Homicide 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

Date filed (Month, Day, Year) OCT 0 5 2009

Rostan Famuil

ROINTAN FARAHIFAR 12150 M.O 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Anapolis road

D43446

Suite B312.

29d. Date signed (Month, Day, Year)

9.30.09

Glandle

			State of Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department of Health / Department / Departme		giene , Reg. No. 4	2009	3327
	Dharisi		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Mildred Pride	Septembe		200 9	1415 M
-	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  PENINGSUL REGIONAL MESICAL CENTER SALISON,	1	4c. Co	ounty of Death	ic
	Funeral Director		5. Social Security Number  6. Sex 1 M 2X F  91  7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Mip.	8. Date of Birth (Month, Day 1 - 3 - 1	y, Year)	9. Birthi Cour	place (State or Foreign ntry)
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	arylar show	<u>_</u>	10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits 1X Yes 2 □ No
	he M	Director	MD Somerset Princess Anne			(10)	
	with	چَ	10e. Street and Number 10f. Zip Code			en of What Cou	ntry?
	feath	Funeral	11974 Edgehill Terrace 21853  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	J.S.F	A . I. Race - Ameri	can Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Event inst roust be notified at once.	by Fur	Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No  If Yes, specify Cuban, Mexican, Puerio  1 ☐ Yes 2 ☑ No  If Yes, Give  1 ☐ Yes 2 ☑ No  1 ☐ Yes 2 ☑ No  Specify:	Rican, etc.)		Black, White,	etc.
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	ed wit	Con	8th Caretaker		Indu	ıstry	
nd	be file d oth even	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Maiden Su	urname)	
ryla	nould d Mer narke natic	ပ္	Unknown Maggie		•		
Maryland	d 2 sh th an 7 Isr traur		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rut			, ,	Code)
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altimore,	Pages tment of tant: If i jury or		X Burial 2 □ Cemation 3 □ Removal from State d□ Donation 5 □ Other (Specify) Cedar Grove Cem 9.30.	2009	Augı	ısta,	GA
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J.	/Medical Examiner		Due to (o as a consequence of):				
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.0. Box	To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours attent death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1		230	d. Date of deliv Month	ery Day Year
ر. ح.	s that gned t e deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
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Vital Records,	<b>Physiclan:</b> The law re this certificate has be al director, page 2 sho	Completed		24a. Was a autop perfor	sy med?	prior to co death?	opsy findings available impletion of cause of
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Division of	ding P th. After t	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Month, Day, Year)  2 ☐ Accident Investigation  28a. Date of Injury 28b. Time of Injury Work?  1 ☑ Accident Investigation  M	28d. Describe h	ow injury o	occurred	
VISI	Atten ir deal ector; by the	Ifica	2   Activided 6   Could not be	28f. Location (S	Street and I	Number or Run	al Route Number,
	tal or rs afte al Dir ed in	Cert	4   Humicide building, etc. (Specify)	City or Tow	n, State)		
	ne Hospi n 24 hou ne Funer bletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cred at the time, o	cause(s) a date and pl	nd manner as s lace, and due t	stated, o the cause(s)
	Withii Cong	ž	29b. Signature and title of certifier 29c. License number	2	29d. Date s	signed (Month,	Day, Year)
	\ \ \		DERZZZ DERZZZ		0	09-24-	-09
	90		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Raza Afzal 100 E. Corrol   St. Sklisbury, Md. 218	٥١			
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	N. E.			
H	Registra	ar	SEP 25 2009 Donne D. Jacke				

			For State Registrar	State of I	Marylan				lealth a	ınd M	F	Reg. No.	200	9 0327
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last     HAJAR     4a. Facility Name (If not institution, give		er)		PAY		Location of	f Death	2. Date of Dea Month, Octobe	r 11 4c. (	, 2009 County of Dea	
	Funeral Director		Casey House  5. Social Security Number 219-08-2816 6. S	ex 7. □ M 2 X F	Age <i>(In yrs.</i> 84	last birthday) Yrs.		ockvi r1 Year Days		24 Hrs. Min.	8. Date of Birth April Day		ntgomer 925 IR	thplace (State or Foreig
-		ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome	cy		y, Town or Lo hersbu								10d. Inside City Limits
th with the	23a or 28 ust be no	Funeral Director	10e. Street and Number 218 Hidden Forest	Court			10f. Zi	2087	77			_	ted Sta	
filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be notified at once.	d by Fune	11. Marital Status  1 □ Never Married 2X Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 ∐Yes 2 If Yes, Give Year or Date	s? XINo		Was Dece If Yes, spe 1 □Yes		ispanic Origin, Mexican, Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify:	
d within 72 ha	giene. er than "natu ine Medical	Completed by	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) College (1-4d	or 5+)	16a. Dece (Give life. House	kind of w DO NOT i	ual Occup ork done d use retired	ation during most d)	of workir	ng		n home	/Industry
ind he file	th and Mental Hygi 7 is marked other traumatic event, II	To Be (	17. Father's Name (First, Middle, Last) Asmikhan Paydar	450		,			Vasil	lia I	(First, Middle, Paydar			
and 2 shr	Health and tem 27 is m other traum		19a. Informant's Name/Relationship (Ahmad Eini -son	Type. Print)		218 F	łidde	n Foi	rest (	Court		ersb	urg, Mo	1. 208//
permit Pages 1 a	Department of H Important: If iter any Injury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)		te Par				1					Town, State , Maryland
nermit	Depar Impor any in		21. Signature of Funeral Service Licer	e gwa	es	1 44	onal 100 P	nd Addre d V. owde	ss of Facility Borgv r Mill	vardt L Roa	Funerad Belt	al H svil	ome, PA le, Mar	A cyland 2070:
} /	nysician Medical xaminer	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Acute  Due to (or	n line.	_ Gang] uence of):		-		cardiac	i respiratory ai	11651,		Approximate Interval Between Onset and Death
Physician: The law requires that the death certificate be executed	physician and the burial-transit	dical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq									
the death certific	by the attending p tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outco 1 ☐ Live birl 4 ☐ Pregnar 9 ☐ Unknow	h 2□Feta nt at time of	death 3	⊒ Ectopic ⊒ Other (s		у			2	23d. Date of de Month	elivery Day Year
ouires that	been signed I should be deta	by	Part II. Other significant conditions of	ontributing to deat	h but not res	ulting in the u	inderlying	cause giv	en in Part I.			obacco u Yes 2	5.7	to the cause of death?  Probably 4  Unknow
n: The law re	certificate has be ector, page 2 sho	Completed	DE Westernels								1 □ Yes	rmed? 20 No	24b. Were a prior to death? 1 □ Ye	
Physician: The law requires t	nis certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	nt 3 🗆 🗆	OA Oth			n <i>(Check only o</i> me 5 ☐ Resid		Other (Sp.	ecify) hospice
	within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	Certification:	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  5 Pending investigation 6 Could not be determined	28e. Place of	Day, Year)	28b. Time of Injury ome, farm, st	М		yat k? Yes 2 □ t	No	28d. Describe f 28f. Location (S City or Tov	Street and	d Number or F	Bural Route Number,
e Hospital	e Funeral letely filled	Medical Co	29a. Certifier (Check only one)  1 CertifyIng Ph	ysician: To the be niner: On the bas and manner	is of examina	owledge, dea ation and/or in	th occurre	d at the ti	me, date an opinion, dea	nd place, th occurr	and due to the red at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)
Toth	withir <b>To th</b> comp	Me	29b. Signature and title of certifier  To Kouche.	hou, n	nD				e number 748	>				nth, Day, Year) 1, 2009
,			30. Name and address of person who Jocelyne Kouatcho	completed cause o	of death (Ite	n 23a) (Type, Iuncas I	Print)	ill 1	Road I	Rock	ville,	Mary	land 20	0855
	Sta		31. Date filed (Month, Day, Year)		istrar's Signa	ature B	R		·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3.-Time of Death Physician/ Year Month Day October 1, 2009 PEDERSOLI MARINHO 1122 hrs Medical Examiner WALDIR 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 8900 Good Luck Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** BRAZIL Months Days Hours Director 341-38-2929 77 April 4,1932 1XM Usual Residence of Decedent 10d. Inside City Limits I Oc. City, Town or Location 10b. County 1 X Yes 2 No "natural", or items 23a or 28a-f show Examiner must be notified at once. Maryland Prince George's Lanham hours after death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 United States 9408 Preslev Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married White Yes 2 X No specify: f Yes, Give Yea Specify. 3 Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) bernit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturinjury or other traumatic event." Completed during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Auburn University Professor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mario Pedersoli Lindorica Ferreira 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Heleni Pedersoli -wife 9408 Presley Place Lanham, Maryland 20706 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Metropolitan Crematory 10/6/2009 1 Burial 2 XCremation 3 Removal from State Alexandria, Virginia Other Specify: Donation 5 21. Signat neral Service Licensee Borala Vores Borawardt Funeral Home, 4400 Powder Mĭll Road Beltsville, Maryland20705 23a. Part Lefter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and fail re. List only one cause on each line. /Medical Death Undetermined Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and or use as the burial - tran 23a,27,28a-f,permE, g896 10/20/09 TT sician/Medical X UNPENDED AMENDED Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown q signed by the a Unknown Phy 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 certificate 26 Place of Death (Check only one) 25. Was case referred to medica Be Other<sub>4</sub> examiner? DOA Residence 6 V Other: Scene ER/Outpatient 3 Nursing Home 5 this Inpatient 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 X No unk Natural Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the unk unk 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 unk Town, State) Suicide unk Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d, Date signed (Month, Day, Year) 29b. 2fq hature and title of certifier 29c. License number October 2, 2009 O.C.M.E. Name and address of person who completed cause of death (Item 23a)

State Registrar

U P. A

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Regist ar's Signature

Laron Locke MD.

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Registrar  1. Decedent's Name	(First, Middle, La	ist)					Date of Dea			3. Time of Death
Physici /Medi		ANN MARIE	RECCHIA					SI	Month SPTEMB	ER 24	4 2009	12:34P
Examir		4a. Facility Name (If	-	ve street and number)		4b. City, Tow	n, or Location of D	eath			ounty of Death	1
Funeral Director		5. Social Security No. <b>078–10–90</b>	95 6. 9		e (In yrs. last birt	thday) If Under 1 You		∕lin.	Date of Birth (Month, Day 2/05/1	Year)	9. Birth	nplace (State or Forei intry) <b>Y</b>
how		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	or Location					T	10d. Inside City Lim
Ba-f s	Director	MD	TALBOT		EASTON							1 X Yes 2 □ i
or 2	Dire	10e. Street and Num	ber			10f. Zip Co	de		1	I0g. Citize	en of What Cou	intry?
s 23a			OOD DR.,	SUITE 406		21601				SA		
"natural", or items 23a or 28a-f show adical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Marrie 3 ▼ Widowed		12. Was Decedent E Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify  1 ☐ Yes 2 ☐		? (Specify uerto Rica	Yes or No- an, etc.)		I. Race - Amer Black, White, pecify:	, etc.
natura Ical E	ted		15. Decedent's E	ducation	16a.	Decedent's Usual O	cupation			16b. Kind	WILL of Business/Ir	
than	Completed	Elementary/Secor	fy only highest gr dary (0-12)	College (1-4or 5-	+)	(Give kind of work de life. DO NOT use re HOMEMAKER	one during most of tired)	working		OMN	HOME	
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± 0 0	To B	BENJAMI	N DIFABB	10			PHYLLI	S TES	AT			
重なさ		19a. Informant's Na		(Type. Print) <b>TER/DAUGHT</b> )	1	Mailing Address (St. 551 TODDS						ip Code)
ant: If item ?		20a. Method of Disp	osition	Removal from State		Disposition (Name or y, crematory or other		Date			ation - City or T	own, State
는 분 등		4 Donation	5 ☐ Other (Speci	fy)	ST. MAR	RY'S CEMET		/28/2	2009 B	ARNE	GAT, NE	W JERSEY
Depa Impo any Ir		21. Signature of Fur	leral Service Live	nsee		22. Name and A	HELFENB	ETN 8	NEWN	AM FI	INERAL.	HOME, P.A
			77									
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nysician		Immediate Cause (I disease or condition	t failure. Ast only Final	one cause on each lin	ne.	200 C D	ARRISON dying, such as car	ST., diac or re	EASTO espiratory arr	м м	<del>2160</del> 1	
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Funeral	5. Social Security Num	ber 6. Sex	7. Age (In	yrs. last birthday)	If Under 1			th(MM/DD/YYYY) g. Bi	rthplace (State or
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cr death with the Maryland y, or items 23a or 28a-f sh rmust be notified at once Funeral Director	11. Marital Status	12. \	Was Decedent Eve			f Hispanic Origin?	( Specify Yes or No		rican Indian, Black,
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To the Ho within 24 To the Fu Completel	29b. Signature and title	and i	manner stated.			icense number		29d. Date signed (A	
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	30. Name and address	- 7 VUSINA	eted cause of deat	h (Item 23a)					
	Pamela E. So		sistant Medica	l Examiner	111 Penn S	treet, Baltimor	e, MD 21201		
State				Signature	Sand				
Registra	111	113 2008	Burn	p. 19	and .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔀 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 0504 Riall Michael 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Wicomico egional If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11–16–1957 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Maryland Director 51 216-70-6382 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show the Madical Evaruiner riust be notified at 1 ☐ Yes 2X No Director MD Somerset Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 13595 Backbone Road 21822 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or ite 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2 📆 No Specify: Specify: White ş 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dishwasher Assisted Living 10 permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygie Important: If Item 27 is marked other ti any Injury or other traumatic event, Im-once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Woodward Riall Frances Kay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13595 Backbone Road, Eden, MD 21822 Sheila Riall - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-5-2009 Shad Point, Maryland Shad Point Cemetery 22. Name and Address of Facility Signature of Funeral Service Licens Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Par . Enter the disease, or complicates that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only on a ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 mail **Physician** - 4mp Ito MA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?-1 □Yes 2 ☑ No CArdioVASCULZR 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 14 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🕊 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 029283 1,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL ST. SALISBUM MS 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29, 2009 Physician 10:55am Carol Esther Smith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Denton Caroline Nursing Home 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 70 May 19, 1939 Director 210-30-1762 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 TX Yes 2 T No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 520 Kerr Avenue USA 21629 items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 🗓 No White Specify. Specify: þ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ht Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Thomas Mink ပ Ima Quesembury 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dee Jackson/Daughter 4204 Saturn Drive, East New Market, Maryland 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 10/1/2009 Easton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207 Lenar 106 Main Street, East New Market, MD 21631 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** leukemie robable /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2□No 3□ Probably 4□Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1□ Yes 2 400 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral I

the

with

Baltimore, Maryland 21215-0036

Certification: To Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

State Registrar

Melinda 136 31. Date filed (Month, Day, Year) OCT 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Ave Lednum 32. Registrar's Signature

CM

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0005325

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

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Due to (or as a consequence of):    Sequentially list conditions, and any leading to immediate cause. Enter Underlying the cause of leasting in death of the cause of leasting in the underlying cause given in Part I.				disease or condition	ווומו 1	a		リ	en	entre	$\alpha$						1	3 y ea	<i>v</i> 5
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sheila Marie Shaw 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 5, 2009 0928 hrs **Medical Examiner** Sheila Marie Shaw 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury 114 Delaware Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Days Hours Months Min Country) NC Director 49 1960 Feb. 1 216-70-6340 1 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 XYes 2 No s 23a or 28a-f show e notified at once. Salisbury or 28a-f shov MD Wicomico Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 114 Delaware Avenue 21801 14. Race - American Indian, Black, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status must be White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No Yes 2 X No specify: Specify: Black авет If Yes, Give Year 1978-1984 4 X Divorced Examiner Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry i. Pages 1 and 2 should be filed within 72 hours is trnent of Health and Mental Hygiene. Trant: If item 27 is marked other than "natura or other traumatic event, the Medical Examir 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Anchorage Nursing & Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Rehabilitation Center Laborer 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loretha Hull Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Carmenita Marie Shaw/Daughte Salisbury, Maryland
Date 20c. Location - City or Town, State 114 Delaware Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, ltimore, crematory or other place) 1 X Burial 2 Cremation 3 rtant: Eastern Shore Vet. Ceretery 10/12/2009 Hurlock, MD Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licenset Salisbury, Maryland 2180 Chapel- 1213 Jersey Road Maryland 21801 Jolley Memorial eles that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Part i. Enter the disease, or compli, Between Onset and failure. List only one cause on each /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed 23a,27,perME, g896 10/22/09 TT Physician/Medical AMENDED X UNPENDED attending physician or use as the burial Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown а Unknown certificate has been signed by the ector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? No 1 🗸 Yes No Yes 2 26 Place of Death (Check only one) 25. Was case referred to medica the Hospital or Attending Physician: Division of Vital Be examiner? Other 4 Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient After this 1 V Yes No 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 1 X Natural Yes 2 No Pending within 24 hours after death Director: d in by the f 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie October 6, 2009 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day,) 32. Registrar's S

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29d. Date signed (Month, Day, Year)

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**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Wolfice Expriser must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, has To the Funeral Director: After this certific completely filled in by the funeral director, after death Director:

For State Registrar Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month October 2009 0140 William Olin Staker, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cecil Elkton Care and Rehabilitation Center Elkton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 X M 2 □ F 1932 AUG 31, Delaware 222-18-1365 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 1 X Yes 2 ☐ No Directo Chesapeake City Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 21915 528 Biddle Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1950— 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🛣 No Specify: White If Yes, Give Year or Dates: 1987 <u></u> 3 

Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Automobile College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Inspector 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Davis George Staker မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Lynn Jones/Daughter</u> 235 Fawn Drive, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) October 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake City, MD 13, 2009 Bethel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE END STAGE Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown BLADDER CANCER Completed PROSTATE CANCENDA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy HYPERTENSION 1 ☐Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

NAMPANA 31. Date filed (Month, Day, Year)

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32. Regist ar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U. PULA

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State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** John Richard Swindell October 2009 8:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Transitions Healthcare Sykesville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 10/30/1931 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F **Director** 212-28-8115 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a 960 Prince George Drive 21784 u.s.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Yes 2 No 10 If Yes, Give Year or Dates: 1951–55 1 ☐ Yes 2 ☑ No Specify: White þ 3 -Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 } s 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Telephone Company</u> Lines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Wilbur Swindell Alice L. Bowers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau 960 Prince George Drive, Sykesviell, MD 21784
e of Disposition (Name of Date 20c. Location - City or Town, State Deborah Snyder (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harkord Mem. Gardens: 10/10/2009 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zulman Funeral Home. P.A. 123 S. Washington St., Havre de Grace, MD 21078 20a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 **□**√No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier

State Registrar

341

216

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Washing

826

32. Registrar's Signature

30. Name and address of person who completed cause of death frem 23a) (Type, Print) mendon

ERNEST

31. Date filed (Month, Day, Year)

	,		For State Registrar	State of N	Maryland / Dep Ce	ertificate of		d Mental Hy	giene Reg. No. 🤈 🏻	328
	Physic /Medi		1. Decedent's Name (First, Midd ELIZABETH B. TR					2. Date of De Month SEPTEM		3. Time of Death 2009 12:45A
	Exami		4a. Facility Name (If not institution 8576 DONCASTER		er)	4b. City, Town, C	or Location of De	eath	4c. County of	
	Funeral Director		5. Social Security Number 578–26–1520	.6. Sex 1 □ M 2 <b>X</b> F	Age (In yrs. last birthda) 82 Yrs.	Months Days	If Under 24 H Hours M	in. (Month, Da	th ay, Year) <b>8, 1927</b>	Birthplace (State or Foreig Country)     MARYLAND
	/aryland f show	ō	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r is ust be retified at	Director	MARYLAND TALBO  10e. Street and Number		EASTON	10f. Zip Code			10g. Citizen of W	
	eath v	eral	8576 DONGASTER	ROAD 12. Was Deceder	4 F	216			JNITED ST	
980	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Medical Exeminer is ust be ratified at	by Funeral	11. Marital Status  1 □ Never Married 2 🗓 Mar  3 □ Widowed 4 □ Divorced	Armed Forces	i? <b>X</b> No	. Was Decedent of lif Yes, specify Cub 1 ☐ Yes 2 🛣 No		(Specify Yes or No lerto Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. WHITE
21215-0036	hin 72 hou e. an "natura Medical E	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)  College (1-40	16a. Dec	edent's Usual Occu e kind of work done DO NOT use retire	during most of v	vorking	16b. Kind of Bu	siness/Industry
21	yd witl	Som	11	College (1-40		LER/COLLE	ECTOR		ANTIQUE	<b>ES</b>
Maryland	uld be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle,  CARROLL L. BE	,				lame (First, Middle L OGLE	Maiden Surname	e)
	and 2 sho ealth and n 27 Is mi er traum		19a. Informant's Name/Relations ROBERT TRAMM		19b. Mai <b>P • O •</b>	BOX 706	and Number or ST. MIC	Rural Route Numb HAELS, MI	er, City or Town, S 21663	State, Zip Code)
Baltimore,	permit. Pages 1 al Department of Hes Important: If item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 🗶 Cremation 4 ☐ Donation 5 ☐ Other (S	3 □ Removal from Stat	20b. Place of Disp	osition (Name of smatory or other planks CREMAT	TON SE	PT. 29 009		City or Town, State
Balti	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service		C T		ELFENBE	IN & NEWN	IAM FUNKE	RAL HOME, P.A.
68760,	tificate be executed  By Medical  By Medic	al Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any beautiful cause or injury that initiated events resulting in death) Last	a. MET Due to (or a b. Due to (ura	s a consequence of):	LUNG C	ANCE	2		Approximate Interval Between Onset and Death
P.O. Box	that the death cer ed by the attendin detached for use	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  Part II. Other significant condition	4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal death 3 at time of death 5	□ Ectopic pregnanc □ Other (specify) _ underlying cause giv		23e. Did t	Mon	e of delivery th Day Year bute to the cause of death?
Records,	w requires been sign should be	eted b	-							3 ☐ Probably 4 ☐ Unknown
	ician: The lav certificate has ector, page 2	Completed	25 Who copy referred to medical					24a. Was - autor perfo 1 □ Yes	osy pr rmed? de	/ere autopsy findings available rior to completion of cause of eath? □Yes 2□No
⋚		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ient 2 ☐ ER/Outpatie	nt 3 🗆 DOA Oth		eath (Check only o		
$\subseteq$	ng After	ition: To	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of In (Month, D	ury 28b. Time of	of 28c. Injur	4 LI Nursing	Home 5 PResident Property 1 28d. Describe I	dence 6 ∐Othe	
Division	al or Atter s after dea il Director d in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined   28e. Place of in	jury - At home, farm, st tc. <i>(Specify)</i>			28f. Location (8 City or Tov	Street and Numbe vn, State)	r or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1  Certifyin 2  Medical	g Physician: To the bes Examiner: On the basis and manner s	of examination and/or it	th occurred at the tin envestigation, in my o	me, date and pla ppinion, death oc	ice, and due to the curred at the time,	cause(s) and mar date and place, ar	nner as stated. nd due to the cause(s)
		Ž	29b. Signature and title of certifier	- Alturn	zu	29c. Licens	05746	8	9/28	(Month, Day, Year)
	srk rk		30. Name and address of person	who completed cause of		Print) 8005.	FALBUT	5, 5	TMEH	ARCG, MI)
	Sta Registra	te ar	31. Date filed (Month, Day, Year)	9 2009 32. Regist	rar's Signature	backer				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician September 2<sup>Day</sup> 2009<sup>Year</sup> Trinidad 1:10P Catalina Cabrera /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 7406 Levte Drive Oxon Hill If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Nov. 8, 1950 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2√2 F 577-86-0043 Philippines 58 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liquiry or other traumatic event, the Medical Evaninar must be matter anong. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director Prince George's Upper Marlboro Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 663 Mt. Lubentia Court 20774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Filipino 1 ☐ Yes 2XX No Specify. \$ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk 12 years Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ρ. Cabrera Paulina Trinidad Agapito ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Mt. Lubentia Court Upper Marlboro, Maryland Belinda C. Cabrera / Companion 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Edgewater, Maryland Kalas Crematory 10/04/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home P.A. alas 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. 5 fter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final CERVICAL CANCER **Physician** END STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes XXXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) other-in-Law House Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specif) Certification: To after death.

| Director: After this d in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1xXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide AX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064983 September 29. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #200 Silver Spring, MD MD 2101 Medical Park Drive Frederick David Min 31. Date filed (Month, Da 32. Registrar's Signature State OCT 0 5 2009 Registrar

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. 25 pay Physician/ 2009<sup>ear</sup> Dorothy Louise Todd 3:28pm м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1 - M 2 - F Apanth, Day, Year 914 Hours 95 220-07-9920 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Towson Baltimore W Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21204 28 Allegheny Avenue Apt. 1702 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 ▼ No Specify Specify: White 3X□ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Deluxe Gift Wrapper & Designer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edna Mae Wight George Nelson French 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number City or Town, State 710 Code)
Allegheny Ave., Apt. 2704 Towson, MD 21204 Mr. Robert F. Todd, Jr. (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Lake View Mem. Park

9/29/2009 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sykesville, MD 21. Signature A uneral Service License AATGHT FUNERACIITHOME & CHAPEL, P.A. Moo W PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e Immediate Cause (Final Physician/ CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate raths. Find Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 Probably 4 □ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, pag Yes To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Tyes Other: 4 Nursing Home 5 Residence 6 X Other (Specif) HUS ACE 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the 29b. Signature ar 29d. Date signed (Month, Day, Year) MJI who completed cause of death (Item 23a) (Type, Print) 6 VALLEY RD TIMOMUM, MD 2300 DULANEY

State Registrar 31. Date filed (Month, Day, Year)

SEPTEMISER

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item per FH 6896 10/19/09 dk
State of Maryland / Department of Health and Mental Hygiene

			1 - State Of State Of Registrar	iviai yiai iu		tificate of	neaith and i Death	-	Reg. No.	2015	33289
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Death
	/Medic		Robert Henry Uhl					9	29 Day	2009	1410 M
	Examin	er	4a. Facility Name (If not institution, give street and num Atlantic General Hospit			Berli	r Location of Death n	l	4c. (	County of Death	0.10
4"	Funeral		·	. Age (In yrs. lasi	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th ,	Worceste 9. Birthpl	ace (State or Foreign try)
	Director		217-30-5040 <sup>1</sup> ∇ M 2□ F	72	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Date of 30/1	937	Coun	MD
	and ww		Usual Residence of Decedent  10a, State 10b. County	10c. City, T	own or Loc	cation				10	Od. Inside City Limits
	Maryl -f sho	tor	MD Worcester	Nev	wark						1 □Yes 2 No
	or 28a	Director	10e. Street and Number	.,,,,,,		10f. Zip Code			10g. Citiz	en of What Count	try?
	23a c 23a c ust by	ral	8347 Langmaid Rd.			2184	1			USA	
	er dea items	Funeral	Armed Ford		13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	)- 1	<ol> <li>Race - America Black, White, e</li> </ol>	an Indian, etc.
936	hours after death with the Maryland tural", or items 23a or 28a-f show al Eronalnet aust be redilled at	þ	1 □ Never Married 2 □ X Married 1 □ Yes 2 If Yes, Give 3 □ Widowed 4 □ Divorced Year or Date	_	1	□Yes Ž No	Specify:			SpecifyWhite	2
9200-91212	thin 72 hours after death with the Marylar e.e. m'natural", or items 23a or 28a-f show Madical Esphiring 1 ast barnelling at	Completed	15. Decedent's Education (Specify only highest grade completed)	Ţ	16a. Deced	lent's Usual Occup	pation	kina	16b. Kin	d of Business/Ind	lustry
7	filed within 72 Hygiene. other than "na'sent, in "sele.	mple	Elementary/Secondary (0-12) 2 College (1-4	lor 5+)		in Fire (	during most of word)		Ra1+i	more Cou	intv
	be filed wit ital Hygien d other th event, the	ပ္ပိ	17. Father's Name (First, Middle, Last)		aptai	III FILE (	18. Mother's Nam		L		incy
_	ed of c	To Be	Robert Uhl				Elizabet				
E	shou nd N mar	ř	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	l and Number or Ru	ral Route Numb	er, City or	Town, State, Zip	Code)
	and 2: ealth a n 27 is er trau		Marlene Uhl / wife				id Rd., N	ewark,	MD 21	1841	
ore	5 ± 5 €		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from Si	ate i		sition (Name of natory or other pla	:	Date	20c. Loc	cation - City or To	wn, State
Baltimore,	t. Page rtment o rtant: If rjury or		4 □ Donation 5 □ Other (Specify)	Gat	The second second second second		em. 10/5/			boro DE	
g	permit. Pag Departmeni Important: any injury o		21. Signature of Funeral Service Licensee	-/		Name and Addre	am St., B			eral Home	9
			23a. Part 1. Enter the disease, or complications that cal	used the death.						1011	Approximate Interval Between
2. F	Physician		shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	n line. OCARD	19%	11150	KOTION			Bul	Onset and Death
1	/Medical		resulting in death)	r as a consequen		INV	2011119			19-11	191111111111111111111111111111111111111
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<b>j</b>	the d	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		ui 5_	TOttlet (specify) _					
ָרָי בי	w requires that the death cer.  been signed by the attendin should be detached for use i	by Pi	Part II. Other significant conditions contributing to dea	th but not resultir	ng in the un	derlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to th	e cause of death?
ğ	equire sen sig ould b	ted t						1 🗆	Yes 2	]No 3 ☐ Prob	ably # Unknown
Hecord	The law r ate has be page 2 sh	Completed	·		•			24a. Was auto	psy	prior to cor	psy findings available npletion of cause of
_	hysician; The law his certificate has t il director, page 2 sl							1 □ Yes	ormed? 2.⊠No	death? 1 □ Yes	2 □No
VItal	Physician; this certific ral director,	Be c	25. Was case referred to medical examiner?  Hospital: 1 □ In	patient 2≭≦ ER	I/Outnation	t 3 DOA Oth	26. Place of Dea			DO#++ (0)	
	n. + 20	n: To	27. Manner of Death 28a. Date of		Bb. Time of Injury	28c. Inju	ry at	ome 5 ☐ Hes 28d. Describe		Other (Specify occurred	//
	Attending It death. ector: After by the fune	atio	2 Accident investigation	, Day, Tear)	прагу	M 1 🗆	Yes 2 □ No				
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building	f Injury - At home g, etc. <i>(Specify)</i>	e, farm, stre	et, factory, office	1850- 111 11-	28f. Location ( City or To	Street and wn, State)	Number or Rura	I Route Number,
_	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fo		29a. Certifier 1 ☐ Certifying Physician: To the b	est of my knowle	edge death	occurred at the t	ime date and place	and due to the	cause(s)	and manner as s	tated
:	e Hos 124 h e Fun letely	Medical	(Check only one) Medical Examiner: On the bar and manner	sis of examination	n and/or inv	estigation, in my	opinion, death occu	rred at the time	, date and	place, and due to	the cause(s)
: 	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	e signed (Month, i	Day, Year)
			Iswith C. Holy ver	1 Pho	J.		\$ 06241		5	7-30-0	79
	- F		30. Name and address of person who completed cause	of death (Item 23	3a) (Type, F	Print)	\$ 06241 WW ST.	C	16	112	72
ζ	5 5 Sta	te	31. Date filed (Month, Day, Year) 32. Fe	gistrar's Signature	1 1	703 01	MW ST.	JUBEN!	Tildy 1	100 2186	3 4
	Registra		UCI U 1 2009   🛝	eur L	2. 10	arked					

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year A. TOHN UNUMB 7:30AM 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MANOR MONTGOMER DOTOMAC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours Min. (Month, Day, Year) 22. 6, 1922 MN 477-12-0175 Director 87 Mar. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD 1 ☐ Yes 2 X No Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6112 Winnebago Road 20816 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates. 1943-45 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than "traumatic event, the Me College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Political Officer CIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file trnent of Health and Mental H rtant: If item 27 is marked of njury or other traumatic ever ည Archibald Unumb Mary Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen A. Unumb/wife 6112 Winnebago Road Bethesda, MD 20816 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Final Journey Crematory 09/30/09 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EARCINOMA Onset and Death CHOLANG10 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ADVANCED if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine THRIVE, FAILYRE attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death bed 1 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 2 N After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cther (Specify) 1 🗌 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057458 09

State Registrar Registrar's Signature

6502 Kenilworth Ave Riverdale, MD

30. Name and address of person who completed dause of death (Item\_23a) (Type, Print)

32

M.D

2009

31. Date filed (Month, Day, Year)

OCT

			1 - For State Registrar	State of Marylan	•	artment of He rtificate of De			jiene Reg. No. 2	09	33291
	Physici		1. Decedent's Name (First, Middle, Las	Geraldine Cri	m Vice			2. Date of Dea Month Sept.	Day	OO9	3. Time of Death 8:10 p M
A STATE OF THE STA	/Medic Examir		4a. Facility Name (If not institution, given Holy Cross Hosp	e street and number)	1200	4b. City, Town, or Lo	ocation of Death or Spring		4c. County	of Death	<u> </u>
	Funeral Director		5. Social Security Number 6. S		• /	If Under 1 Year	- '	8. Date of Birth Jan. 29	1	9. Birtho	gomery  blace (State or Foreign  ofry)  Carolina
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	the Mar 28a-f sh	Funeral Director	MD Montgome:	ry S	ilver	Spring  10f. Zip Code			l0g. Citizen of	What Cour	1 ŽYes 2 □ No
	s 23a or	eral Di	13424 Tamarack		- Tab	20904	1.011.070		1	JSA	
9800	ours after de Iral", or item L'Examiner I	5	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of Hisp. fYes, specify Cuban, l∐Yes 2 X No S	and Origin? (Spe Mexican, Puerto Specify:	Rican, etc.)	Bla	ck, White, o	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinist ment be profilled at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupation  kind of work done durit  OO NOT use retired)  Jnit Secret	ing most of worki	ng	16b. Kind of B Hol Rehab	y Cro	oss
	2 should be filed and Mental Hy, is marked othe aumatic event,	To Be C	17. Father's Name (First, Middle, Last) Wesle	y Vernon Crim		18	B. Mother's Name		Maiden Surnan Chappe		
Baltimore, Maryland	and 2 shou ealth and N n 27 is mar er traumal		19a. Informant's Name/Relationship ( Deborah Shields-		1	ng Address (Street and					22304
imore	permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any injury or other trau		20a. Method of Disposition 1	nemoval nom State   Th	lace of Dispo emetery, cren ion Ce	sition (Name of natory or other place) metery	Oct. 5		20c. Location - Burtons	•	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licent	randKline	- 1	. Name and Address or rphy Funeral	•	Wilson B	lvd., Ari	lingto	n, VA 22203
- de	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the death one cause on each line. Respirat			such as cardiac c	or respiratory arr	rest,		Approximate Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequence Seizure	uence of):						
	uted d insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence Syncope	uence of):						
68760,	ificate be executed g physician and st the burial-transit	edical Exa	that initiated events 'resulting in death) Last	Due to (or as a consequence).	uence of);						
O. Box 6	e death certi he attending ed for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)				te of delive	ery Day Year
rds, P.	quires that the en signed by to uld be detach	ρ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause given i	n Part I.				he cause of death?
of Vital Records,	The law requir cate has been s page 2 should	Completed						24a. Was a autops perform	sy mag/?	Were auto prior to co death? 1 ∐Yes	opsy findings available impletion of cause of
Vita	iysician; Tis certifica director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	FB/Outpatier	Other	6. Place of Death	,		ner (Specif	60
	ding Ph h. After th funeral	tion: T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe ho			77
É	al or Attending s after death. Il Director: After ed in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre			28f. Location (S. City or Town	treet and Numb n, State)	per or Rura	al Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my know iner: On the basis of examination and manner stated.	wledge, death tion and/or in	n occurred at the time, vestigation, in my opini	date and place, ion, death occurr	and due to the c ed at the time, c	cause(s) and m late and place,	anner as s and due to	tated. the cause(s)
		Ň	29b. Signature and title of certifier	Pahm an	nic.	29c. License nu D6637		2	9d. Date signe 9/30/0		Day, Year)
1	20	-	30. Name and address of person who of Majid Rahmanian	completed cause of death (Item	23a) (Type,	Print)	Spring	MD 209	10		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Begistrar's Signat		C. CIIVCI	- h0,				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Physician 3:00 A M Reese /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner 11:11 NUrsing Orsica entreville Center H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, ueen 5. Social Security Number 9. Birthplace (State or Foreign Country)

Maryland 6. Sex 7. Age In yrs. last birthday) **Funeral** 1 M 2 □ F Months 212-12-3570 Usual Residence of Decedent Director 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show injury or other traumatic event, the Wedical Examiner must be notified at 1 Yes 2 No Director tune's aSONVI 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Folces:
1 Pres 2 No 1944
If Yes, Give
Year or Dates: 1946 1 ☐ Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No è 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie ဂ ngton Sr. CottMan Mailing A dress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD. 21638 3 -GrasonVille Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 109 Grasonville 4 Donation 5 Dother (Specify) 22. Name and Address of acility
Henry Funeral
Sid Washington 21. Signature of Funeral Service Licensee HOME, P.A. ambridge, MD. 21613 23a. Pawl. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiomyon wars disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner URANE Sequentially list conditions, if any, Isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner uence of) 10005 The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to lo as a consequence of): Box 68760. Physician/Medical attending p F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۳. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Completed by Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy this certificate 1 □Yes 2 No of Vital 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To : After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 ☐ Pending investigation 12 Natural death. 1 ☐ Yes 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

**OCT 06** 

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cause of death (Item 23a) (Type, Print) aldemen

egistrar's Signatur

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2009 Year Oct. 6 10:45 PM WOLFORD Clarence Mead /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 17314 Ontario Drive Washington

9. Birthplace (State or Foreign Country) Hagerstown
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, **Funeral** Year) 1K M 2 □ F Months Days Hours Min Director 218-30-9375 1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐Yes 2 ☑ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17314 Ontario Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married 1 ☐Yes 21 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Correctional Officer State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ Charles Downs Wolford Ida Virginia Marks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Linda J. Wolford - Wife</u> 17314 Ontario Drive, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Rest Haven Cemetery Hagerstown, Maryland 10/10/09 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home O'TOB. Kalut 415 E. Wilson Blvd. Hagerstown, Md. 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 ancer 347 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital 1 Tes 2 No 1 🔲 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) and title of certific 29c. License number ress of person who completed cause of death (Item 23a) (Type, Print)

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, certificate | this After after death

Director: 24 hours a within 2.

28a-f show

or items 23a or

"natural".

or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

permit. Pages 1 and 2:s Department of Health a Important; If item 27 is any injury or other trau

/Medical

Examiner

attending physician

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cate has been signed page 2 should be det

Baltimore, Maryland 21215-0036

Box 68760

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580 Northern

Hagerstown MD

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dember Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital Baltimore City Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplac Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2XX Months 88 2/28/1921 NC **Director** 239-32-2716 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show must be notified at 1x Yes 2 □ No **Funeral Director** Prince George Bowie MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number with 1 ö 23a 20720 USA 12617 Willow Marsh Lane Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Architect Government ortant: If item 27 is marked other tha injury or other traumatic event, the I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၀ Janie Bright <u>Harry Lee</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 12617 Willow Marsh Lane, Bowie, MD 20720 Janice Williams/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Duplin Memorial Gard 1 22. Name and Address of Facility 10/3/2009 Teachey, NC 20010 21. Signal of Funeral Service Licensee WATSON F H 3435 14th ST N W WASH. DC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOXIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 2 2 🗌 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ည 28a. Date of Injury 27. Marrher of Death 1 Natural eral Director: After this filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 24 hours TW Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES TOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) **OCT 0 5 2009** 

32. Registrar's Sign

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State Registrar
1. Decedent's Name (First, Middle, Last)

e of Maryland / Department of Health and I	Mental Hygiene
Certificate of Death	Reg. No.
	2. Date of Death

3. Time of Death

· Y	Physicia /Medic Examin	al
П	Funeral	

	Physici /Medic		Elizabeth Ellen Wes	sley			October 2,	<sup>Day</sup> 2009 Year	7:40 A M
4	Examin		4a. Facility Name (If not institution, give street and number) Genesis Nursing Home		4b. City, Town, or LaPlata	Location of Death	,	4c. County of Death Charles	
	Funeral Director		5. Social Security Number  5. Social Security Number  6. Sex 1 M M M F 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 13, 19	ar) 9. Birthp Coun 28 Washi	ace (State or Foreign htry) ngton, DC
	Maryland a-f show fied at	tor	10a. State 10b. County 10c. City	, Town or Loc Ldorf	cation			10	0d. Inside City Limits 1 □Yes 2 No
	with the	Director	10e. Street and Number 2075 Tanglewood Drive		10f. Zip Code 206	 01	10g.	Citizen of What Coun	try?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rudified at once.	by Funeral	11. Marital Status  1			lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e Specify: Whit	etc.
Maryland 21215-0036	vithin 72 hourshe. sne. than "natural"	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E	dent's Usual Occup kind of work done o DO NOT use retired Analyst	ation during most of work d)	ing	. Kind of Business/Inc	lustry
nd 2	e filed v al Hygie I other t vent, III	Be Co	12 17. Father's Name (First, Middle, Last)	Брасс	maryse	18. Mother's Nam	e (First, Middle, Maid		
yla	ould b Ment larked latic e	인	Charles William Cox	т		Ethel	Matilda	Allen	
, Mar	and 2 sh salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type. Print) Elizabeth Ann Andrews/Daughter					ty or Town, State, Zip	
Baltimore,	. Pages 1 ament of He tant: if item jury or oth		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Ced 4 □ Donation 5 □ Other (Specify)	emetery crem Iar Hil	sition (Name of natory or other place 1 Cemete	ry 10/6		itland, MD	
Balt	permit Depar Impor any in		21. Signature of Funeral Service Licensee			Hill Road O	kon Hill, Mai		45
	Physician /Medical Examiner		23a. P. 11. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequ	cle	er the mode of dyir	ng, such as cardiac	or respiratory arrest,	LALD (S	Approximate Interval Between Onser and Death
0,	executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen						
68760,	icate be physicia the bu	dical	d						
O. Box	ires that the death certificate be executed signed by the attending physician and to be detached for use as the burial-transit	ıysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ery Day Year
rds, P.	The law requires that the ate has been signed by the bage 2 should be detache	ed by Phys	Part II. Other significant conditions contributing to death but not resu	ılting in the ur	nderlying cause giv	en in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death? pably 4 🗌 Unknown
al Records,	<b>Physician:</b> The law re this certificate has be al director, page 2 sho	Completed by					24a. Was an autopsy performed	? death?	psy findings available mpletion of cause of 2  No
Σ; Σξ	Physician: r this certificaral director, p	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ I		Oth	or:	h (Check only one)		
Division of Vital	Jing F	Certification: To	1 ☐ Yes 2 XXNo	28b. Time of Injury	28c. Inju	4 LANUTSING FIG	ome 5 ∐ Residence 28d. Describe how in	e 6 ☐ Other (Specifinity occurred	<u>v)                                      </u>
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At homicide building, etc. (Specify				City or Town, Si		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in 1	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my know and manner stated.  XX Certifying Physician: To the best of my know and manner stated.	wledge, death tion and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To t To th	N	29b. Signature and title of certifier		29c. Licens	SSY S	29d.	Date signed (Month,	Day, Year) Z ZOO
2	- 6		30 Name and address of person who completed cause of death (Item	70 €	Print) LIX	18 (8)	UTER W	ACROCF	Md. 20602
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signat	La Ke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** CI 8:01 AM 2000 St. John Wellington 28 Welesley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Dea 4b. City, Town, or Location of Death Examiner Washington Adventist Takoma Park Hospital Montgomery If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 01/08/1931 Min. 1 X M 2 □ F Months Days Hours 78 Jamaica 577-19-8308 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar is ust be notified a once. 1 ∑Yes 2 No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2412 Franklin Street NF 20018 Jamaica Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Jamaican ò 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Ezelkiel Wellington Celestine Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Devon Wellington/son 1808 Metzerott Road #38 Adelphi MD 20783 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cem. 10/03/09 22. Name and Address of Facility 420 H Street NE BK Henry Funeral Chapel Wash DC 20002 emi Part Y. Enter the disease, or complications that outsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROTIATE **Physician** AMANGED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. ed by the a detached f 9 I Inknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 ☐ Yes 2 No 1 ☐Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dec. 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo, 20012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Milton Broseker, Jr. 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 16, 2009 Year 0308 hrs **Medical Examiner** Milton Broseker, Jr. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** 7. Age (in vrs. last birthday) Country' Months Days Hours Min Director 214-50-9561 07/29/1948 Maryland 1X M 2 F 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No N/A Maryland Baltimore hours after death with the Maryland 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code notified at 302 S. Duncan Street United States 21231 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 XMarried 1X Yes Yes, Give Yea Unk Yes 2X No specify: Specify: White Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "T injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Sanitation Bakerv 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Milton Theodore Broseker, Sr. Violet Jane Cessna æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Shirley Broseker - Wife 302 S. Duncan Street Baltimore, Maryland 21231 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/20/2009 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A.

401 S. Chester Street Baltimore, M

22d. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Maryland 21231 Approximate Interva **Physician** Between Onset and M di al Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed Physician/Medical AMENDED 23a,27, PII per ME G896 10/28/09 TT X UNPENDED the attending physician led for use as the burial -Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Chronic obstructive pulmonary disease Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed' Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 DOA 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 18, 2009 O.C.M.E. OK beley 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

31. Date filed (Mon

egistrar's Signatu

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AMEND ITEM#26perPHYS, G896, 10719/09 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Year **Physician** BURGESS 5: 45 PM RANKIN SHIRLE 2009 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON ROAVO CARROLL WESTMINSTER If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Year) 1□M 2×F Months Days Hours Min. 075-14-6064 Yrs. NEW Director 1920 YORK Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No CARROLL Director WESTMINSTER the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 USA WASHINGTON ROAV 21 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "ni Elementary/Secondary (0-12) College (1-4or 5+) WELL READ BOOKS CCOUNTAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RANKIN LAWRENCE FLORENCE DELAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 and 2 s it of Health an SYKESVILLE MO 21764 FLETCHER/DAU. 150 BRASS EAGLEDR. MARGARET 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2XTCremation 3 ☐ Removal from State ŏ permit. Page Department of Importent: If any njury or once. 10/17/2009 WINFIELD `4 ☐ Donation 5 ☐ Other (Specify) SOUTH CARROLL CREM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JNZUMBMW FH & MON. Co. ELDER BURG-MO 21784 6028 SYFESVILLERO TU 23a. Part 1. Enter the disease, oxoomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ascul 50 /Medical Due to as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as the burial-transit Due to (or as a consequence of) Box 68760, attending physician be Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 4☐ Pregnant at time of death Division of Vital Records, P.O. the detached 9 Unknown 9 Unknow signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2**X** No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 ☑ No rsing Home 5X Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After To the HoepItal or Attanding 1 Natural 2 Accident 5 Pending investigation 2 🗌 No death 1 Tyes Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 68 Poole RI 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Leo John Bukowinski 11:00 PM OCTOBER 2009 13 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death SAINT AGNES HOSPITAL BALTIMORE N/A 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Days 1X M 2□ F 80 225-38-1781 30. 1929 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 644 Coleraine Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1795, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1951 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 1952 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Construction Assembly Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Bukowinski Mary Daciek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albin Bukowinski, Brother 644 Coleraine Road Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Donation 5 ☐ Other (Specify) Woodlawn Cemetery 10/17/09 |Woodlawn, Maryland 21. Signature of Funeral Service Consee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK DAYS disease or condition resulting in death) Due to (or as a consequence of) PNEUMONIA DAYS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) YEARS CARDIOMYOPATHY Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ∐Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner physician Box 68760 P.O. Records,

burial-tra the attending p signed by t cate has b page 2 si certificate l director.

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

<u>م</u>

Completed

Be

**Funeral** 

Director

show

2 should be filed within 72 hours after death with the Maryla is and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f shov raumatic event, it a Madical Examiral must be notified at

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Examine Physician/Medical After this c

Completed Be

BUKOWINSKI, LEO Division of Vital or Attending Physician: n 24 hours after death.

e Funeral Director; A pletely filled in by the fu within 24

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , M.D OCTOBER, 13th, 2009 Pagooa

BALTIMORE,

21229

MD

State Registrar

31. Date filed (Month, Day, Year)

KADHIKA

32. Registrar's Signature

900 CATON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KALISETTI,

DHMH 17 Rev 1/2001

AVENUE,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death

**Physician** /Medical **Examiner** 

**Funeral** 

Director the Maryland 28a-f show at must be notified with 1 ō 23a Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. items 2 ō 'natural" other than is marked Department of Health ar Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760,

nock or heart failure. List only on Immediate Cause (Final Almemia disease or condition resulting in death) Due to (or as a consequence of) sastrolutestina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Pancrentic Cance physician and as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown 5 Other (specify) 1 Yes 2 No the signed by þ Completed 25. Was case referred to medica Be examiner? Hospital: 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: (Month, Day Year) 5 Pending investigation 2 Accident after death filled in by the 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 24 hours 29a. Certifier (check only Medical completely one) within 2 To the 29b. Signatur 29c. License number and title of certifie Resogo 30. Name and address of person who completed causs of death (Item 23a) (Type, Print)

Minder

Registrar's Signature

1 - For State Registrar Decedent's Name (First, Middle, Last) 3. Time of Death BARA 15 2009 18:44 tobes 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Dec. 16 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 M 2 X F Yrs Maryland 63 218- 58-7600 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 😾 No Director Harford Edgewood Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21040 U.S.A. Funeral 1962 Chipper Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates: þ 3 ₩ Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Essex Cummunity College Lead Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Car1 Clayton McCarty Etta ပ္ Brantley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1262 Chipper Dr. Edgewood, Maryland 21040 Joseph A. BouthnerJr( Son ) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 Burial 2x Cremation 3 Removal from State Bayview Crematory Inc. 4 Donation 5 Other (Specify) 17,2009 Baltimore, Maryland Name and Address of Facility
 Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number. City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state.

State Registrar

Camille

31. Date filed (M

Mic

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

1 - For State Registrar 1. Decedent's

31. Date filed

29b. Signature and title of certifier

Halanen Month, Day, Year) DCT 1,9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 S Greene 37. Registrar's Signature

**Physician** 

/Medical

Examiner

Funeral Director

or items 23a or 28a-f show

**Physician** /Medical Examiner

attending physician and for use as the burial-trar

signed by the a

certificate has been s rector, page 2 should

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Director

Funeral

Be Completed by

ပ

Examiner

Medical Certification: To Be Completed by Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Registrar	State of M		Certificate				g. No.	0 7720
. Decedent's Name (First, Midd	le, Last)					2. Date of Death	1	3. Time of Death
Boggo	Continu					October	Day Year	1332 PM
a. Facility Name (If not institution	n, give street and number	·)	4b. City,	Town, or Location	on of Death	OC III	4c. County of De	ath
Inversity of ma	culand medic	al Cente	- Ba	siti mar	e		N/A	
Social Security Number		ge (In yrs. last birth	Months	1 Year If Und Days Hour	der 24 Hrs. s Min.	8. Date of Birth (Month, Day,	Year) (	rthplace (State or Foreign Country)
250-88-3404 Usual Residence of Decedent		61 <sup>Y</sup>	rs.			APR. 1,	1948   SOU	TH CAROLINA
0a. State 10b. Count		10c. City, Town	or Location					10d. Inside City Limits
MARYLAND N/A			BALTI	MORE				1 XYes 2 ☐ No
0e. Street and Number			10f. Zip			10	g. Citizen of What C	country?
2826 WINDSON	R AVENUE			21216			U.S.A.	
1. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Deced	dent of Hispanic	Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
1 Never Married XXMa	ried 1 □ Yes 2 <b>X</b> If Yes, Give	₩Vo	1 ☐ Yes 2			,/	Specify: B]	
3 ☐ Widowed 4 ☐ Divorce			Donadorila Harri			Т		
(Specify only high	nt's Education est grade completed)	(	Decedent's Usua 'Give kind of wor life. DO NOT us	rk done durina n	nost of worki	ng	6b. Kind of Busines	s/muustry
Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)	NERAL U				FOOD SEI	RVICE
7. Father's Name (First, Middle	Last)			1	other's Name	(First, Middle, M	laiden Surname)	
LEO CENTURY				E	DNA CA	ANTY		
9a. Informant's Name/Relation	ship (Type. Print)	19b.	Mailing Address	(Street and Nu	mber or Rura	al Route Number,	City or Town, State	Zip Code)
Jane B. Centu	ry/Wife	28	26 Wind	sor Ave	. Balt	cimore,	Maryland :	21216
a. Method of Disposition  XXBurial 2 ☐ Cremation	2 Domovol from State	cometery	Disposition (Nam ; crematory or of	ne of ther place)		Date 2	20c. Location - City of	r Town, State
4 □ Donation 5 □ Other (			ON CEME	TERY	10-23	3-09	LANSDOWNE	, MARYLAND
1. Signature of Eugeral Service	Deensee			d Address of Fa M C BRO MNORTH			FUNERAL H	OME P.A.
23a. Part 1. Enter the disease, of shock, or heart failure. Lis	r complications that cause t only one cause on each	ed the death. Do no	ot enter the mod	e of dying, such	as cardiac	or respiratory arre	est,	Approximate Interval Between
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esulting in death)	Due to (or a	a consequence of	): 1	الإرح				10093
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any, leading to immediate ause. Enter Underlying ause (Disease or injury	Due to (or a	s a consequence of	i): •					,
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,	Duc to (or a	a consequence of	).					
	d							
	00-16	e of pregnancy					23d. Date of d	elivery
		2 Fetal death	3 Ectopic p.	regnancy			Month	Day Year
3b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of death	5 Other (sp	ecify)				
3b. Was decedent pregnant	1 Live birth	at time of death	5 ☐ Other (sp	ecify)				
Bb. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown				ırt I.	23e. Did tob	acco use contribute	to the cause of death?
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1  Yes 2  No 9  Unknown  art II. Other significant condit  5. Was case referred to medical examiner?  1  Yes 2  No 7. Manner of Death 1  Natural 5  Pendi	1 Live birth 4 Pregnant 9 Unknown  ons contributing to death  Hospital: 1 Mainpal 28a. Date of in	but not resulting in display the second sec	the underlying co	ause given in Pa	ace of Death	1  Ye  24a. Was ar autops perform 1  Yes 2	24b. Were prior to death 1 1 Yes	Probably 4 \( \sqrt{\frac{1}{2}} \) Unknown autopsy findings available completion of cause of \( 2 \sqrt{No} \)

State Registrar 29c. License number

Baltimore

MD

21201

29d. Date signed (Month, Day, Year)

October 16 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

December 1 American From Models   Last   Centrude   C			1 - State Registrar			,	C	ertificate of [	Death	,	Reg. No.	6000	0000
Comment   Comm	Dhysicia	m/	1. Decedent's Name (Fil	rst, Middle, La	ast)				**	2. Date of Dea	ath	Voor	3. Time of Death
Ciclohrist Center for Hospice Care    Control Service   Control Se							mara	ta		Octobe	er 16	, 2009	6:00 P M
Special Security Numbers   Control   Total	Examin	er								ath	4c.	•	
212—344—3182   Tour Control    100 C										e O Data of Bird	ib.		
The state of the part of the p	Director		212-34-318	32	1 □ M 2 💢 F					1. (Month, Da 4-28-	y. Yea <i>r</i> ) 1937	Count	trv)
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30. Name and address of person who completed cause of death (Item 23a) (Type Print)	<b>८</b> ₹ 6 8		29b. Signature and title	e Con	convi 1	C						1	)ay, Year)
Lagu traine and address of detsort who completed cause of dearn open zaar type. Printi			0				22a) /Tim-	Print)	- · · ( /				
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State 31. Date filed (Month, Day, Year)  OCT 1 20000				-							- 1		,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

### 09-07999

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Robert	Gwyn Co		S1 - For State	ate of l	Marylan	d / Depar	rtment of <i>tificate of</i>	Health	and	Menta	al Hyg		. 2	0	0 0000
		F	eqistrar  1. Decedent's Name (First, Midd	In Last)			illicate of	Dealii			2.	Date of Death	j. No. <u> </u>	3. T	ime of Death
Medic	Physicia al Examir		n. Decedent's Name (First, Midd Robert Gw		x III							Month October 14			2218 hrs
(			4a. Facility Name (if not institution			er)	1	4b. City, Tow Bel Air	m, or Le	ocation of	Death		4c. County of E Harford	eath	
			981 Phillips Place				a blab as A	If Under	Voor	If Linder	24Hrs	8 Date of Birth		J. Birthpla	ce (State or Foreign
	Funeral Director		5. Social Security Number	6. Sex		Age (In yrs. la		Months	Days	Hours	Min.		11, 1974	Country	/)
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	any	- }	Usual Residence of Decedent  10a. State 10b. County			10c. City,	Town or Locat	ion						- 1	d. Inside City Limits
	ž ,		Maryland Harf	ord			Bel Ai	7-						1	Yes 2X No
9	BAILIMOINE, IND 21219-0030  The state of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number	OLG			Der Ar	10f. Zip C	ode			10	g. Citizen of What	Country?	
0	the M	ă	981 Phillips F	lace				210	)14				USA		
15/0	with ns 23 be no	<u>a</u>	11. Mantal Status	12	2. Was Deced	lent Ever in U.	S. 13. Wa	s Decedent es, specify	of Hisp	anic Origi Mexican	n? (Spec	cify Yes or No- ican, etc.)	14. Race - / White, e		Indian, Black,
1	death r iter nust	Funeral		Married 1	Yes	2X No		_	_			, ,	Specify: V	Thite	,
	after	by F		or	es, Give Year Dates:		1	Yes 2			ind of wo	rk done	16b. Kind of Busin		
	hours natur		15. Decedent's Education (Sp Elementary/Secondary (0-12		College (1-4		16a, Deceder during π	nost of worki	ng life.	DO NOT	use retire	d)	Top: raing or busin		,
20	in 72 han "	bet	12	'	College (1-	, 0, 3.,	Т.	aborei	_				Constru	ctio	n
2000	d with	Completed	17. Father's Name (First, Middl	e, Last)				abolei	1	8.Mother's	s Name (	First, Middle, M	Maiden Surname)		
7	ked o	Be	Robert Gwyn C	ox II								th J. I			
40.40	ould b	2	19a. Informant's Name/Relation				1						nber, City or Town,		- 1
	d 2 sho d 2 sho lth and n 27 is		Elizabeth J.	Cox,	Mother		981 P	<u>hillir</u>	os I	lace	Be1	<u>Air, N</u>	Mary Land 20c. Location - C	2101	<u>∕ı</u>
	S 1 an f Hea f iter		20a. Method of Disposition  1 Burial 2 X Crematic	on 3	Removal from		Place of Dispo crematory or o		e or cen	lietery,			1		
	altimore, rmit. Pages 1 ar spartment of Hee nportant: If ite					lM∩+	ro Cre	matory	/ Ir	nc.	10/	16/09	Baltimo	re,	Maryland_
<u> </u>	balt permit. Departi Import injury		21. Signature of Funeral Service	e Licen ee	Thomas	s Grego	$r$ $\frac{22}{C}$	Name and A remati	iddress LQN	Soci	ety .	Of Mary	yland, "Ir	ıc,	1 04 000
			4 Donation 5 Other 21. Signature of Funeral Service 23a. Part I. Enter the disease,	or complica	tions that cau	ised the death	Do not enter	the mode of	<u>eder</u> dying,	ICK such as ca	KOAO ardiac or	Balt11 respiratory arr	est, shock, or hear	y Lan	Approximate Interval
S .	Physician 'Medical	W 10	failure. List only one caus	e on caon	mito.									J	Between Onset and Death
-	<i>i</i> aminer		Immediate Cause (Final diseas or condition resulting in death)			consequence of	nadone of):	& MOT	DITTI	ie) i	BEOX	ICALLO	0		
			Sequentially list conditions,	b										$\rightarrow$	
		ner	if any, leading to immediate cause. Enter Underlying Cause		e to (or as a o	consequence	of):								
	_	Examine	(Disease or injury that initiated events resulting in death) Las	· · · ·	e to (or as a	consequence	of):								
	O, e be executed ysician and burial - transit	<u> </u>		d.		1 as n	oted po	er ME	289	8 12	/1//	09 TT		-+	
	O, e be exe sician a burial -	edical	XUNPENDED	X	AMENDED "	23a,PI	oted po 1,27,28	a-f,p	erMI	I, g8	98 1	2/4/09	TT		
1	760 icate lights	\¥	IF FEMALE: 23b. Was decedent pregnant in	the	23c. If yes, o	utcome of pre		etal death	3	Ectopi	c pregnar	ncy	23d. Date of o	delivery Day	y Year
6	Records, P.O. Box 6876 The law requires that the death certificate reate has been signed by the attending phy page 2 should be detached for use as the t	Physician/M	past 12 months?			nt at time of d		Other (Spec	ify)						
1	BOy death the att	ysi			9 Unkno							OO- Did	tobacco use contril	huto to th	o cause of death?
	or the sd by the etache	by PI	Part II. Other significant con		ontributing to	death but not	resulting in the	underlying	cause	given in Pa	art I.	23e. Did 1 ✔ Ye		Probat	
1	S, P ires tl signe d be d	9 9	Cardiomegal	<u>.y</u>								24a. Was			psy findings available
•	ord; w requisited the second	Completed										auto	psy p		mpletion of cause of
	Reco	E	ľ									1 🗸 Yes		<b>✓</b> Yes	2 No
	al Rian: 1 sertific ctor, 1	Be C	25. Was case referred to med examiner?		wital.					e of Death Other	_		Invitaria Ca	Other: \$	Coope
	of Vital Records, ing Physician: The law requir After this certificate has been s funeral director, page 2 should	10	1 ✓ Yes 2 No			npatient 2	ER/Outpatie		OA	ry at Wor		g Home 5	Residence 6 we how injury occurre		ocene
	n of Vital I ding Physician: h. : After this certiff e funeral director,	ᄩ	27. Manner of Death  1 Natural 5 P	ending		Day,Year)				Yes 2X	_ 1	unk	• •		
	SiO Atten r death ector: by the	gţ	2 Accident In	vestigation	29a Diace	) / 14 / 09 e of Injury - At	Fd 10 home, farm, st	: 10 ptr	n office	building, e	etc.			er or Rura	al Route Number, City
	Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the stafter death.  an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	d	ould not be etermined	(Specify)	house		,			- 1	or Town, 981 Ph	State) Llips Pl.	B <u>e</u> 1	Air, MD
הא הי	To the Hospital or Attend within 24 hours after death For the Funeral Director: completely filled in by the		29a. Certifier	Physiciar	n: To the bes	t of my knowle	edge, death occ	curred at the	time, o	date and p	lace, and	due to the car at the time, dat	use(s) and manner e and place, and d	as stated ue to the	i. cause(s)
non	To the within To the comp	Medical	29b. Signature and title of cer	а	and manner s	tated.				se numbe			29d. Date sign		
			Auntit 1	A. 18	4001	MA			O.C	.M.E.			October 15	, 2009	
			30. Name and address of per	on who co	mpleted caus	se of death (Ite	em 23a)			· · · · ·					
			Pamela E. Southall	, MD	Assistant	Medical Ex	caminer :	111 Penn	Stree	et, Baltiı	more, N	MD 21201			
		Stole Stole	31. Date files Month Dan Ye	WH19	1 32 B	eistrar's Stype	atup								

Registrar

### 09-07940 James Collins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mes	Collins		State of Maryland / Depart	tment of ficate of		and Me	ntal Hy		- N- C (1)	1.0	2220
	Physici	ian/	Registrar  1. Decedent's Name (First, Middle,Last)	-			12	2. Date of Deat	g. No. h	<b>3</b> . T	ime of Death
edica	al Exami		James Collins					Month October 13	Day Year 3, 2009	C	0143 hrs
1			4a. Facility Name (if not institution, give street and number)	41	c. City, Town,	or Location	n of Death		4c. County of	Death	
1			Johns Hopkins Hospital		Baltimore	)			N/A	A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Y	ear If Un	der 24Hrs.	8. Date of Birt	h(MM/DD/YYYY)		ce (State or
	Director		220-68-0786 1XM 2UF	43 Yrs.	Months D	ays Hou	rs Min,	T 1 2 .	3, 1966	Foreign Country	Maryland
			220-68-0786   1X   M 2   F   Usual Residence of Decedent	45				pury Z.	<u>5, 1900 T</u>		- truly rand
	10 y			own or Locatio	n				-	10d	. Inside City Limits
	d how		Maryland Baltimore	Midd	lle Riv	TO 18				1 [	Yes 2 No
	rylan a-f sl	당	Maryland Baltimore 10e. Street and Number	MIGG	10f. Zip Code			10	og. Citizen of What	t Country?	
	or 28	ire	/04 M 111 D 1 D 1		21	220			LIC	٨	
	ith th	uneral Director	401 Middle River Road  11. Marital Status  12. Was Decedent Ever in U.S.	13 Was			rigin? ( Spe	cify Yes or No-	US.		Indian, Black,
	ath w items ist be	ner	1 Never Married 2 X Married Armed Forces?		s, specify Cul				White,		,
	ter de	교	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 ,	Yes 2 🗸	No specif	īv:		Specify:	White	9
	ırs af t <b>ural</b>	db	or Dates:	6a. Decedent's	$\Lambda$			ork done	16b. Kind of Busin		
	2 hou	) še	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo:	st of working	life. DO NO	T use retire	ed)			
36	thin 7 thao thao edica	횰	12	Truck	Drive	r			Truc	kino	
21215-0036	ed wi	Completed	17. Father's Name (First, Middle, Last)				er's Name (	First, Middle, M	Maiden Surname)	113115	
218	oe file ntal H iked e	Be (	William Collins			1	Susa	an Akon	om		
2	ould I	2	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	Address (St	treet and N	umber or Ru	ıral Route Num	ber, City or Town,	State, Zip	Code)
8	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "eastural?", or items 23a or 28a-f show any lojury or other traumatic event, the Medical Examiner must be notified at noce.		Daniel Roland Collins, Son	401 M	iddle 1	River	Road	Middl	e River,	MD 2	21220
ص	l and Heal Fiten			ice of Dispositematory or other	ion (Name of	cemetery,		Date	20c. Location - C	ity or Town	n, State
Baltimore,	Pages ent of ot: I		4 Description 5 Other Specific	ro Crer		Tnc	10/	16/09	Baltimo	re. M	faryl and
₫	nit. H artme sorta ury or		21. Signature of Funeral Service Licensee Thomas Gregor	22 Na	me and Addr	ess of Faci	lity				
ä	Dep Ioju		- homow X	1 558	emation Fred	n Soci	lety (	Ot Mary Baltim	land, In	C. vland	1 21228
Pł	ysician		23a. Part I. Enter the disease, or complications that caused the death. D	o not enter the	mode of dyi	ng, such as	cardiac or	respiratory arre	est, shock, or hear	Ar Ar	oproximate Interval etween Onset and
	Medical		failure. List only one cause on each whe. Immediate Cause (Final disease a, Multiple Injuries							, i	Death
د قر	caminer		or condition resulting in death)  Due to (or as a consequence of):		***	-					
			Sequentially list conditions, b								
		ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause								
		Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
}	cuted nd transi	<u> </u>	d								
١ _	te be executed ysician and burial - transit	edical	UNPENDED AMENDED								
	cate b physic he bur	Me	IF FEMALE: 23c. If yes, outcome of pregna	ncy					23d. Date of de	eliv <b>ery</b>	
687	ertific ding e as t	ian/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death			3Ecto	pic pregnan	су	Month	Day	Year
Box 6876	eath c atten for us	sic	1 Yes 2 No 9 Unknown 9 Unknown	5 Othe	er (Specify)						
B.	that the death certificate ned by the attending phy detached for use as the	Physicia	Part II. Other significant conditions contributing to death but not rest	ultina in the un	derlying caus	se given in	Part I.	23e. Did to	bacco use contribi	ute to the c	cause of death?
P.O.	w requires that as been signed t should be deta			Ü	, ,	J		1 Yes	2 V No 3	Probably	4 Unknown
Ś	quire en sig uld b	ted						24a. Was a	an 24b. We	ere autops	y findings available
9	aw re nas be 2 sho	월						autop: perfor		or to comp ath?	letion of cause of
Rec	The cate	Completed						1 ✓ Yes		✓ Yes	2 No
Division of Vital Records,	iog Physician: The law After this certificate has uneral director, page 2 sl	Be (	25. Was case referred to medical examiner? Hospital: 4 Insertion 2 4 5			ace of Deat					
Ē	hysic r this al dir	P	1 ✓ Yes 2 No Inpatient 2 ✓ E			Other <sub>4</sub>				Other:	
٥	liog Ph After tl funeral	Ë	1 Month Day Year)	8b. Time of Inj 0006 hrs	· _	Injury at Wo	_		now injury occurred ped out secon		window
į	death ctor: y the	Certification:	2 Accident Investigation			Yes 2					
:≝	ipital or Atteo ours after death neral Director: filled in by the	≝	3 V Suicide 6 Could not be 28e, Place of Injury - At hom		, factory, offic	ce building,		or Town S	tata)		Route Number, City
Ω	spita hours neral fille	Ö	4 Homicide determined (Specify) Single Famil						er Street, Baltim		
17	To the Hospital or Atteodiog Physician: The law requires that the death certificate within 24 hours after death, within 24 hours after death.  To the Functal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	<u>8</u>	one) 2 ✓ Medical Examiner: On the basis of examination and								use(s)
1	To t withi To tl	Medical	and manner stated.	vooligalit		ense numbe			29d. Date signed		
		-	29b. Signature and title of certifier								Juy, rour)
			2-12-11			C.M.E.			October 13,	2008	
			30. Name and address of person who completed cause of death (Item 2:		Donn Cir-	of Deli:	nore Mr	21201			
		ļ	Donna M. Vincenti, MD Assistant Medical Exami		Penn Stre	ei, baitir	nore, ML	7 2 1201			
	S	tate	31. Date file (1007), Pay Ye 2009 32. Registrar's Signature	had	D						

OCME

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Pleas	se Type or Pri				. Ensure A Health and N	-		•	
		for State Registrar		Ottato of the	y	•	tificate of			Reg. No.	2 11 10	1330.
		1. Decedent's Name	e (First, Middle,	Last)					2. Date of D	eath Day	/ Year	3. Time of Death
Physici /Medio		Rush	William	Duckwort	h				Octobe	r 10,	, 2009	3:15 A <sup>M</sup>
Examir				give street and number,	)			r Location of Death	1		County of Death	
<u> </u>			Cendall		- // /	44:44 (- )	Silver If Under 1 Year	Spring If Under 24 Hrs.	Lo Data of Bi		Montgome	J
Funeral		5. Social Security N 711-10-3		6. Sex 7. Ag 1 🖾 M 2 🗆 F	ge (In yrs. 18 82	as t birthday) Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D April	ay, Year)	Cour	place (State or Foreign ntry) t Virginia
Director		Usual Residence of			02				APLIL	30,	1921 Wes	- VIIgIIIIa
ylanc how	١. ا	10a. State	10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
e Mar	cto	Virginia	Culpep	er	Bue	na						1 ☐ Yes 2√ No
iff the	Dire	10e. Street and Nur					10f. Zip Code	4			izen of What Cour	itry?
2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Eventina must be notified at	Funeral Director	11104 Fra	nk Road		F ! . ! ! .	140.1	22733	lii- O-i-i-0 /O	if . V N		S.A.	on Indian
ter de	Fu	11. Marital Status 1 ☐ Never Marr	ied 2□ Marris	12. Was Decedent Armed Forces: 1 ∑Yes 2 ☐	>	0 13.	f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerti	Rican, etc.)		14. Race - Americ Black, White,	etc.
urs af	by	3 X Widowed		If Yes, Give Year or Dates:	195		1∐Yes 2∏No	Specify:			Specify: Black	k
2 hou	Completed	(Cna)	15. Decedent's	s Education		16a. Dece	dent's Usual Occup	pation during most of work	kina	16b. Ki	ind of Business/In	dustry
ithin 7 ne. <b>nan "r</b>	nple	Elementary/Seco		t grade completed) College (1-4or	5+)	`life. I	DO NOT use retire	d)	wig	l		
ed wi lygier ner th	ပ္ပ			4		Di	stributor		/F1 - 1 B 41 - 1 - 1	1	wspaper (	Company
be fill Hed ot	Be	17. Father's Name Rethas D	•					18. Mother's Nam Edna Ma			Surname)	
hould Me mark	은	19a. Informant's N				10h Mailir	na Addrose (Straat	and Number or Ru			r Town State Zir	Code)
id 2 s Ith ar 27 Is				z (Daughter	-)			L St., Si		-		
s 1 ar f Hea item		20a. Method of Dis		.z (baughter	20b. PI	ace of Dispo	sition (Name of natory or other place	1	Date		ocation - City or To	
Page: lent o nt: If ry or			☐ Cremation 3 5 ☐ Other (Spe	3 ☐ Removal from State			National		0/16/09	Cu	lpeper, '	٧A
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventment must be notified at once.		21. Signature of Fu				- 127 W	2. Name and Addre	ess of Facility	ral Hom	ρ		
B a L a		X-10	nnis	Allen	n	5	03 N. Mai	in St., C	ulpeper	, VA	22701	
		23a. Part 1. Enter t shock, or hea	he disease, or cart failure. List o	complications that cause	d the death ine.	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory	arrest	those	Approximate Interval Between
Physician		Immediate Cause disease or condition	on	_ Bladd	er a	anu	r. tran	sitima	Call	met	astalic	Onset and Death
/Medical Examiner	н	resulting in death)	- (	Due to (or as	a consequ	ience of):	/			/~		
	<u></u>	Sequentially list co	nditions,	b	a consequ	ence of):						
uted 1 Insit	Examiner	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	rlying injury	\$ 200 10 (0) 41	a osmoodo	.01.00 0.7.						
be executed cian and ourial-transit	Exa	that initiated events resulting in death)	S	C Due to (or as	a consequ	ience of):						
Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician tely filled in by the funeral director, page 2 should be detached for use as the buria	ca			d								
rtifica ng ph as th	Physician/Medica	IF FEMALE:										
eath certific attending p	an/	23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth	2 🗌 Fetal	death 3	☐ Ectopic pregnand	су			23d. Date of deliv Month	ery Day Year
at the dea by the at tached fo	Sici	1 ☐ Yes 2 l	□No	4 ☐ Pregnant 9 ☐ Unknown	at time of d	eath 5	Other (specify) _				WOUTH	Day Teal
hat th ed by detacl	Ph			ns contributing to death	but not resu	lting in the u	nderiving cause giv	ven in Part I	23e. Did	tobacco u	use contribute to t	he cause of death?
iires tha signed d be det	d by						,g g		10	Yes 2	□ No 3□ Prol	bably 4 Unknown
w requir s been s should	Completed								24a. Wa		T	opsy findings available
ne law e has ge 2 s	m m								auto	opsy formed?	prior to co	empletion of cause of
in: Tificate		25. Was case refer	rred to medical			<u> </u>		26. Place of Dea	1 Yes		1 □ Yes	2 No
ysicia is cert direct	o Be	examiner? 1 ☐ Yes 2 💢		Hospital:	ient 2 🗆	ER/Outpatier	nt 3 DOA Oth				6 ☑Other (Speci	Daughter's
ding Physician: The In. After this certificate har funeral director, page	Certification: To	27. Manner of Deat		28a. Date of In	ury	28b. Time o			28d. Describe			**RESTRENCE
endin sath. or: Af	atic	1 X Natural 2 Accident	5 Pending investiga	ation	ay, rour,	,,		Yes 2 □ No				
r Atterdeterde	ij.	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ned   28e. Place of Ir	jury - At ho tc. (Specify	me, farm, str	eet, factory, office			(Street and	nd Number or Rura e)	al Route Number,
ital o Ins af ral Di												
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)		g Physician: To the bes Examiner: On the basis and manner s	of examinat							
To the within 2 To the complex	Med	29b. Signature and	title of certifier	and manner's	lated.		29c. Licens	se number		29d. Da	ite signed (Month,	Day, Year)
FSFö		)		1/12		MA		-	371	11	1/12/10	7
11		30. Name and add	ress of person	who completed cause of	death (Item	23a) (Type.		1058		16	11010	<del></del>
4		MAT	ry B	PRESTO	N	MD	661	Univers	sity 2	and	, Oraa	es VA
Sta		31. Date filed (Mor	nth, Day, Year)	32 Régis	trar's Signat	ture	- 4			,		9
Registi	rar		II:I 1 9 i	CUUS / LE	41 8	7. 190	CLASSIE					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	ate of waryland	Certificate of		Reg. I	P P P P P	2220
	Physicia	an	Decedent's Name (First, Middle, Last)	000			2. Date of Death	Day O Year	3. Time of Death
No.	/Medic		LEIDY CIU	1160	14.07.7		10 11	0/009	7.00 M
	Examin	er	4a. Facility Name (If not institution, give street		46. City, 10Wn,	or Location of Death	10	4c. County of Death	
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) If Under 1 Year		8. Date of Birth (Month), Day, Yes	9. Birth	place (State or Foreign
	Director		2/24266/6 1×M	<sup>20</sup> 73	Yrs. Months Days	Hours Min.	12/02/1	19:20	. Carolina
7	M M		Usual Residence of Decedent  10a. State 10b. County	10c. City	r, Town or Location		/ /		10d. Inside City Limits
200	f sho	jo		1337 311,		Baltimore			1 Yes 2 □ No
4	128a-	Director	Maryland N/A  10e. Street and Number		10f. Zip Code	salumore	10g.	Citizen of What Cou	ntry?
1	23a ol	alD	1217 West Fayette Street			21223		U.S.A	4
0	ems (	Funeral	11 Marital Status 12. W	as Decedent Ever in U.S	S. 13. Was Decedent of	Hispanic Origin? (Spectar, Mexican, Puerto F	cify Yes or No-	14. Race - Ameri Black, White,	can Indian,
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1	□Yes 2□No Yes, Give <b>X</b>	1 □Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,	Specify:	
00-	a lieu within 7. nous ariel ueath with the maryand other than "natural", or items 23a or 28a-f show vent, the medical Examplest must be medified at	ed b	^	ear or Dates:	16a. Decedent's Usual Occi	2017	16b	Kind of Business/Ir	Black dustry
7 5	n na Nedic	Completed	15. Decedent's Education (Specify only highest grade com		(Give kind of work done life. DO NOT use retir	e during most of working ed)	g		,
212	giene gritha	E O		ollege (1-4or 5+)	Heavy Equ	ipment Operato	r	Constru	iction
nd	tal Hy d other	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	len Surname)	
yla	and Mental be a said many many and Mental be a said marked of raumatic even	ဥ	Ed Gaine					nna Gaines	
Mar	h and 7 Is m raum		19a. Informant's Name/Relationship (Type. P	rint)	19b. Mailing Address (Stree				p Code)
, e	Healt Healt em 2	0 4	Edward Charles Baker  20a. Method of Disposition	20b. Pi	lace of Disposition (Name of			206 Location - City or T	own, State
nor	ayes ent of t: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	val from State	emetery, crematory or other pla	i i	047/00		1 4 3 d
Baltimore, Maryland 21215-0036	perfilt. Tages I also should be filed within 72 filods after beath with the wallytal beathment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its medical Examination in the multiple of once.		21. Signature of Funeral Service Licensee		Mt. Zion Cemet 22. Name and Add		0/17/09	Lansdowne,	<u>Ivialyialiu</u>
ä	Depar Impo		23a. Part 1. Exter the disease, or complication of the complicatio	(lelle	Estep E	Brothers Funera	Service, P. A	1	
			23a. Part 1. Fi ter the disease, or complication shock or heart failure. List only one call	ns that caused the wath	. Do not enter the mo	ym , such as carollac o	respiratory arrost,	217	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	Pneum	onia				Onset and Death
7	/Medical xaminer		resulting in death)	Due to (or as a consequ	ience of):				
	xammor	<u>.</u>	Sequentially list conditions, b.	Due to for as a consequ	records.				
Ж 2	nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Date to for us a consequ	rence cry				
30	ial-tra	Examiner	resulting in death) Last	Due to (or as a consequ	ience of):				
68760,	physician and the burial-transit	Physician/Medical	d						
	E D SE	Med	IF FEMALE:				-		
Box	attendir for use	ian/	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregna ☐ Live birth 2 ☐ Fetal	death 3 Ectopic pregnar			23d. Date of deliver Month	/ery Day Year
_= 0	the s	ysic	1 TVec 2 TNo 4	☐ Pregnant at time of de ☐ Unknown	eath 5 ☐ Other (specify)				
P.O.	ned by detac	/Ph	Part II. Other significant conditions contribu	ting to death but not resu	ulting in the underlying cause g	jiven in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
ords	been signed by the should be detached	d by	Hypertension : E	Enal Stage	Renal Diceas	se	1 ☐ Yes	2 No 3 Pro	bably 4 🔀 Unknown
000	as bee 2 shou	Completed	Atrial Fibrillation	-			24a. Was an	24b. Were aut	opsy findings available
A P	nte has	mo					autopsy performed	? death?	ompletion of cause of 2 □ No
ital	ertifica	BeC	25. Was case referred to medical examiner?			26. Place of Death			
<b>7</b>	his ce	၉	1 ☑Yes 2 ☐ No	1∐Inpatient 2月X	ER/Outpatient 3 DOA		ne 5 Residence	e 6 ☐ Other (Spec	ify)
O U	After t	io io		Ba. Date of Injury (Month, Day, Year)	28b. Time of lnjury 28c. Inj		8d. Describe how it	njury occurred	
isio	death	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	lo Place of Injury - At he	M 1 [ me, farm, street, factory, office	□Yes 2□No	8f Location (Stron	t and Number or Ru	ml Route Number
Division of Vital Records,	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify	/)		City or Town, S.	tate)	ar moute reamber,
- 4	within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 CertifyIng Physician	n: To the best of my know	wledge, death occurred at the	time, date and place, a	and due to the caus	e(s) and manner as	stated.
a de	n 24   he Fu	Medical		On the basis of examinat and manner stated.	tion and/or investigation, in my	opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
Ę	To the company	M	29b. Signature and title of certifier	4.1		nse number 325/2		Date signed (Month	
			Brian J. Bro					Oct 11,	
	1		30. Name and address of person who comple	ted cause of death (Item	23a) (Type, Print)	1 Martial (	Pouter	Rec Himm	21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

09-08033

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Olga Gladkova Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 15, 2009 2020 hrs Gladkova 01ga Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Min. Country) Russia Director 22 Yrs M 2x F n/a Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ıny 1 X Yes 2 No 3 23a or 28a-f show notified at once. Baltimore City Md. with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 Rear 21231 Russia 17 North Chester St. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. Armed Forces? death v 1 XNever Married 2 X No White Yes P Specify Divorced If Yes, Give Year 1 Yes 2 X No specify: hours after þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) t. Pages 1 and 2 should be filed within 72 hou trment of Health and Mental Hygiene. reant: If item 27 is marked other than "nat or other traumatic event, the Medical Exa Completed College (1-4 or 5+) Elementary/Secondary (0-12) Student Baltimore, MD 21215-0036 12th Student 4yrs. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ludmila Gladkova 01eg Gladkov Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Oleg Gladkov (Father) 2001 Gough Street Baltimore, Md.20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition October crematory or other place) Burial 2 X Cremation 3 Removal from State 22,2009 Baltimore,Maryland Bayview Crematory Important: injury or oth Donation 5 Other Specify: 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Lice 1201 Dundalk Avenue Baltimore, Md. 23a. Part I. Enter the diseasel or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death 'Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran Physician/Medical tending physician a AMENDED UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 Unknown ۾ Completed 24b. Were autopsy findings available of Vital Records, 24a. Was an prior to completion of cause of autopsy performed? death? has 1 V Yes ✓ Yes 2 page 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 this No 1 V Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury After 27. Manner of Death Pedestrian struck by auto Certification: Oct 15, 2009 Year) 0000 hrs Yes 2 V No Natural Division Pending death To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)
Eastern Avenue & Chester Street, Baltimore, MD 24 hours after 3 Could not be Suicide determined (Specify) Major Road / Highway 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wilder Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 16, 2009 O.C.M.E. -1 440 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32. Registrar's Sig ature State

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Physicia	
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Funera Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marcial Event. In the Department of the contraction of the profiled at any one of the contraction.

Physician /Medical Examine

Baltimore, Maryland 21215-0036

	For State Registrar	Olaio o	-	•	ficate of L		R	eg. No. 2 0 0 9	33303		
	1. Decedent's Name (First, Middle, La	st)					Date of Deat     Month	th Day Year	3. Time of Death		
cian lica!	Dorothy	Vear]	1	H	ill			16,2009	1:20 p M		
iner	4a. Facility Name (If not institution, giv	re street and number)		41	b. City, Town, or	Location of Death		4c. County of Dea			
	1929 Wareham Ro	oad				Dundalk		Ba	altimore		
1	Social Security Number 6. S		e (In yrs. last birt		f Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	( Year) 9. Bit	thplace (State or Foreign ountry)		
r	292-30-5822	1□ M 2🔀 F	76	Yrs.	loriura Daya	Tiodis Will.	January		Kentucky		
	Usual Residence of Decedent		10a City Tayya	ou Loost	la a				10d. Inside City Limits		
ctor		Md. Baltimore 10c. City, Town or Location  Dundalk									
Funeral Director	10e. Street and Number 1929 Wareham	Road			10f. Zip Code	21222	1		g. Citizen of What Country?  USA		
ner	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was	s Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Race - Am			
5	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	1 ∐Yes 2 ☑ N If Yes, Give Year or Dates:	No		Yes 2X No		moan, etc.)	Black, White Specify: Wh			
Completed	15. Decedent's E (Specify only highest gra	ade completed)		Deceden (Give kind life. DO	t's Usual Occupa d of work done d NOT use retired	ation luring most of work )	ing	16b. Kind of Business	/Industry		
E O	Elementary/Secondary (0-12) 12 years	College (1-4or 5	)+)	I	Entrepre	neur		Self-E	mployed		
Be	17. Father's Name (First, Middle, Last,	)	<u>I</u>				e (First, Middle, I	Maiden Surname)			
To B	George Washing	gton Hollar	nd			Lu	Ellen Ho	olland			
-	19a. Informant's Name/Relationship (	(Type. Print)	19b.	Mailing A	Address (Street a	and Number or Rui	al Route Numbe	r, City or Town, State,	Zip Code)		
	Nancy Hill	Daughter	<u>.</u>	4601	Springw	ood Ave.	Baltimo	ore, Md. 21	206		
	20a. Method of Disposition				on (Name of ory or other place	i	Date	20c. Location - City or			
	1	fy)	1	ns O	f Faith	119,		Rosedale,	Maryland		
A STATE OF THE STA	21. Signature of Funeral Service Licer	on Con	nelle		lame and Addres nnelly F 10 Solle		ome Of I Road, I	undalk, P. undalk, Mo	A. 21222		
H	23a. Part 1. Enter the disease, or conshock, or heart failure. List only	plications that caused	I the death. Do	ot enter t	the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between		
1	Immediate Cause (Final disease or condition	· C.C	PD						Onset and Death		
1	resulting in death)	Due to (or as	a consequence of	of):							
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
Exar	that initiated events resulting in death) Last										
Medical		<b>d</b>									
ledi											
Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □ Ec 5 □ O	ctopic pregnancy ther (specify)			23d. Date of de Month	əlivery Day Year		
P	Part II. Other significant conditions	contributing to death b	ut not resulting in	the unde	rlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?		
ed by	Liver Conge	cancer	Sr	nal	c cell	ca	100	es 2□No 3□F	Probably 4 Unknown		
olete	Conge	stive h	eart,	fai	lure		24a. Was a	n 24b. Were a	autopsy findings available completion of cause of		
Completed			1				autops perfor	m <b>v</b> ed∙? ∣ death?	s 2 \( \sigma\) No		
BeC	25. Was case referred to medical					26. Place of Deat		7	3 2 2 110		
	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatient	3 □ DOA Othe	er: 4 Nursing He	ome 5 Resid	ence 6 □Other (Sp	ecify)		
tion: 1	27. Manner of Death  Natural 5 Pending  Accident investigatio	28a. Date of Inju (Month, Da		ime of njury	28c. Injury Work			ow injury occurred			
Certification: To	3 Suicide 6 Could not b	28e. Place of Init	ury - At home, fai c. <i>(Specify)</i>	rm, street,	, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,		
	29a. Certifier 1 Certifying Pl	hysician: To the best	of my knowledge	doath o	sourred at the tir	no, data and place	and due to the	cauco(c) and manner	as stated		
Medical	(Check only one)	miner: On the basis o and manner sta	f examination an	d/or inves	stigation, in my o	pinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)		
2	29b. Signature and title of certifier	lason	<b>(</b> )		29c. License			29d. Date signed (Mor			
		completed cause of d	leath (Item 23a) (	(Type, Prin	nt) 12 -	4		10/19/0			
	31. Date filed (Month, Day, Year)	mpbell				Tunor	e, jue	2123	<b>/o</b>		
tate trar	OCT 19 20	109 Lenn	a A.	par	Kal						

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			For State Registrar	State of M	laryland		artment of F rtificate of	leaith and N Death	_	giene Reg. No. 🥠	DHO	200
			Decedent's Name (First, Middle)	, Last)					2. Date of De	ath	LIUJ	3. Time of Death
	Physicia		HENE AN	DREAS HO	STVI	K			Month	Day	ZJOG	QUO PM
	/Medic Examin		4a. Facility Name (If not institution	111			4b. City, Town, o	r Location of Death			nty of Death	
			HOWARD COUNTY		INTP	TAL	· Cor	MIA		l:	MAR	0
	Funeral Director		5. Social Security Number 217–34–4928	6. Sex 7. A	ige <i>(In yrs. la</i> 83		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 9/26/	1926	9. Birthp Cour	place (State or Foreign ntry) Norway
	pu »		Usual Residence of Decedent  10a. State 10b. County		100 City	. Town or Lo	notion.				T-1	0d. Inside City Limits
	f shor	ŏ	MD Howa:	ra	Toc. City	,	ott City				Ι.	1 □ Yes 2 No
	the N	Director	10e. Street and Number	Lu		11110	10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	h with	al Di	10105 Carillo	n Drive			21042	2		Unit	ted St	ates
	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Evan her must be mothered	Funeral	11. Marital Status 1 □ Never Married ※ Marr	12. Was Deceden Armed Forces ied 1 □Yes 24	t Ever in U.S	3. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. F	Race - Americ Black, White,	
5-0036	hours af tural", or	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 □ Yes 2 No	Specify:		Spe	AATT	ite
		Completed	15. Deceden (Specify only highes	's Education st grade completed)		(Give	edent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of	Business/In	dustry
2121	witl the	omp	Elementary/Secondary (0-12)	College (1-4or 2	5+)		Radio Off	Ť		Merch	nant M	arines
	be filed trail Hygid dother event, to	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam			ame)	
aryland	D = 6 0	To	Atle Hestvik					Sigr	id Hols	tad		
Mar	S S S		19a. Informant's Name/Relations					and Number or Rui		-		
	1 and Healt em 2 ther		Carol Hestvik  20a. Method of Disposition	- wife	20b. Pi		5 Carillo osition (Name of	on Drive 1	Ellicot		MD 2 on - City or To	
altimore,			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		_   c∈	emetery, cre	matory or other place rematory	ce) ¦		Hanove	•	
Ħ	permit. Page Department of Important; If any injury or once.	,	21. Signature of Funeral Service						- 1		•	ly F.H. Inc.
ñ	an Jed		Lout for	C:	M014	111 4	112 Old (	columbia 1	Pike El	licott	City,	MD 21043
			23a. Part 1 Enter the di ase, or shock, or heart fail re. List	complications that cause only one cause on each	ed the death line.	. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	- Acuto	3 CG	REBR	DVASCUL	AR AC	UDEN	7		Onset and Death 20 MOURS
	/Medical Examiner		resulting in death)		s a consequ	,				0 ( 20	c=	SYETTES
		ĕ	Sequentially list conditions, if any, leading to immediate	D.	s a consequ		NIC UP	2015450	UUAL	1)1504	30	3 POTTES
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.								
Ď,	e exe sian ar urial-t		resulting in death) Last	Due to (or a	s a consequ	ence of):						
98760	ficate be executed physician and s the burial-transit	edical		d								
_			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnal	ncy		**		23d	Date of deliv	erv
. Box	death certi e attending id for use a	Physician/M	in the past 12 months?	1 ☐ Live birth	at time of de		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	<u></u>			Month	Day Year
л. О	at the by th	hys	9 ☐ Unknown	9 ☐ Unknown								
	w requires that the d been signed by the should be detached	ρ	Part II. Other significant condition	-		-		en in Part I.				he cause of death?
0	requi	eted			SILL	J-410	240		10			bably 4 Unknown
Vital Records,	as 2	Completed	Mergrow						24a. Was autop		b. Were auto prior to co death?	opsy findings available empletion of cause of
<u></u>	in: Th	ပ္ပ	1HP52 uncut 25. Was case referred to medical	37 AWLE	MIA			26. Place of Deat	1 □ Yes	2 <b>X</b> No	1 ☐ Yes	2 <b>N</b> o
>	ysicla is cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 □ I	ER/Outpatie	nt 3 DOA Oth				Other (Specia	f <sub>(/</sub> )
D 0	ding Physiclan: The Ih. After this certificate hifuneral director, page		27. Manner of Death  Natural 5 ☐ Pendin	28a. Date of In	ijury	28b. Time o			28d. Describe			
<u>0</u>	tendii eath. or; A the fu	catic	2 Accident investig	gation			M 1	Yes 2□No				
Division	lor At after d Direct	Certification:	4 Homicide determ	:200. Place 01 1	njury - At hoi etc. <i>(Sp</i> ec <i>ify</i>	me, farm, st	reet, factory, office		28f. Location (	Street and Nu wn, State)	mber or Rura	al Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certification of the funeral director, the funeral director director, the funeral director director directors direc			ng Physician: To the besi								
0	the H thin 24 the F mplete	Medical	one)	Examiner: On the basis and manner:	stated.							
	<b>6 ½ 6</b> ፩	<	29b. Signature and title of certifier	lu.	~		29c. Licens	LG > //.		29d. Date sig	mea (Month,	sta G
•		-	20. Name and address of participation	who completed savies =	death /lto-	23a\ /T	Print)	0714		101	12/5	7.0.0
			30. Name and address of person  \( \text{NM} \) \( \text{O} \) \( \text{NMM} \)  31. Date filed (Month, Day, Year)  \( \text{O} \text{T} \) \( \text{Q} \)  \( \text{O} \text{T} \) \( \text{Q} \)	4.1000 mc	107	24 L	TTLZ PA	TUKTINT	PARKI	Nama	Colu	meia mo
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signat	ure Assa	Ked					
	Registr	ar	0011920	100 Sens	of for.	18						

DHMH 17 Rev 1/2001

1 - For State Registrar

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

29b. Signature a

31. Date filed (Month, Day,

9

**Funeral** 

For State Registrar			$C\epsilon$	ertifica	te of L	Death		Re	g. No. '	MIC	131
I. Decedent's Name (First, Middle								2. Date of Death		20 Year	3. Time of Death
Margaret M. Har	rtman							October	17,	2009	12:10Рм
a. Facility Name (If not institution,	-				; Town, or dalk	Location	of Death			ounty of Death Baltimon	
Heritage Nursin	6. Sex	7. Age (In vrs.	last birthday		r 1 Year	If Under	24 Hrs.	8. Date of Birth			place (State or Foreign
220-09-8797	1 □ M 2 □XF	88	Yrs.	Months		Hours	Min.	1474074	920	Mar	y Land
Jsual Residence of Decedent											
0a. State 10b. County	-		ty, Town or L								10d. Inside City Limits 1   Yes 2   No
Maryland N/	'A	Ba.	ltimor		p Code			1.10	o Citiza	en of What Cou	
0e. Street and Number  812 S. Bouldin	Stroot				224					ed Sta	-
1. Marital Status	12. Was Dec	edent Ever in U.	.S. 13	. Was Dece	edent of H	ispanic Or	igin? (Sp	ecify Yes or No-		I. Race - Amer	
1 ☐ Never Married 2 ☐ Marrie	ed 1 ☐Yes	orces? 2 <b>X</b> No		If Yes, spe	ecify Cuba	ın, Mexicai	n, Puerto	Rican, etc.)		Black, White,	
3 ☐Widowed 4 ☐ Divorced	If Yes, G Year or D			1 ☐ Yes	ZIZINO	Specify:			S	Specify: VV	
15. Decedent' (Specify only highest			I (Giv	edent's Usu e kind of wo	ork done d	during mos	t of work	ring 1	6b. Kind	d of Business/Ir	ndustry
Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT L Nemake	use retired	)			Don	mestic	
7. Father's Name (First, Middle, L	_ast)					18. Mothe	er's Name	e (First, Middle, M			
Adam Krepka	7							bindzerk		,	
9a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mai	ling Addres	s (Street a	and Numb	er or Rui	ral Route Number,	City or	Town, State, Zi	ip Code)
Gary Hartman -	Son		7546	Ives	Lan	e Bal	timo	ore, Mary	land	1 21222	
Da. Method of Disposition		20b. F	Place of Disp cemetery, cre	oosition (Na	me of other plac	e)	1	Date 2	0c. Loca	ation - City or T	own, State
1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (Sp		State	lantic				10/1	9/2009 G	len	Burnie	, Maryland
1. Signature of Funeral Service L	icensee		Ľ	22. Name a David 101 S.	J. W	s of Facili eber ster	Fune Stre	eral Home	s P.	A. Mary	land 21231
23a. 1911. Enter the dise 1931, or o shock, or heart failure. List of	complications that	caused the deat									Approximate Interval Between
mmediate Cause (Final lisease or condition	PI	JEU	MO	NII	A					1	Anset and Dath
esulting in death)	a. Sue to	(or as a conseq	juence of):	OLICE	-11.	- 0	Pi k	MAIND	W 0	1100	501100
equentially list conditions,	CH KU	1100	19711	EVC	1/41	EP	ULI	nonar	7 1	SEAS	E 207 FA
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):	OT	~ A	7		APE			100000
hat initiated events esulting in death) Last	Due to	(or as a conseq	uence of):		TK)	1 17	IOL	1175		+	1071
	A. Sucto				,						
· · · · · · · · · · · · · · · · · · ·	d										
IF FEMALE: 23b. Was decedent pregnant		tcome of pregna							23	d. Date of deli	very
in the past 12 months? 1 ☐ Yes 2 █ No	4 ☐ Preg	birth 2 Feta nant at time of o		☐ Ectopic ☐ Other (s		У				Month	Day Year
9 Unknown	9 □ Unki										
art II. Other significant condition	ns contributing to d	eath but not res	ulting in the	underlying	cause give	en in Part I					the cause of death?
DEWE	MILI	T						1 ☐ Yes	s 2 🔲	No 3 Pro	babiy 4 🗌 Unknown
								24a. Was an autopsy	,	24b. Were aut	opsy findings available ompletion of cause of
								perform	ed?	death?	2 □No
5. Was case referred to medical examiner?	Hoonite!			-	10::			h (Check only one			
1 Yes 2 No		Inpatient 2	· · · · · · · · · · · · · · · · · · ·			4 🖭 Ni	ursing Ho	ome 5 Resider			ify)
7. Manner of Death  1		of Injury oth, Day, Year)	28b. Time Injury	of M	28c. Injury Work		No	28d. Describe how	w injury	occurred	
	aแบก			IVI	1 📖	Yes 2□	INO				
2 Accident investiga 3 Sulcide 6 Could not determine		of Injury - At h	ome form	troot footo-	office			28f. Location (Str.	00t 01	Numberon	ral Poute Number

29d. Date signed (Month, Day, Year)

OCTOBER 17,2009

10

State Registrar

o completed faure of death (Ilem 23a) (Type, Frint)

29c. License number

1160

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ OCTOBER 13. 200<sup>°</sup>9°° CONRAD HANKIN 7:40 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON 9. Birthplace (State or Foreign Country) MD 5. Social Security Number If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days Hours Min 08-26-1932 213-30-4114 Director Usual Residence of Deceden iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD BALTIMORE PARKVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 WALTHER BLVD. #1514 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No "natural" Specify: 3 Widowed 4 Divorced WHITE Year or Dates nt of Health and Mental Hygiene.
It item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CUSTOMER SERVICE REPRESENTATI BGE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MORRIS HANKIN TEMA t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS HANKIN/WIFE 8820 WALTHER BLVD., #1514, PARKVILLE, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 10-16-2009 BALTIMORE, MD 4 Donation 5 Other (Specify) SHAAREI ZION CONG. 22. Name and Address of Facility SOL LEVINSON & BROTHERS, 21. Signal re of Funeral Sprvice Licen ee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Scho disease or condition resulting in death) 19 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examinet Due to or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 Tes or Attending Physician: 25. Was case referred to medical of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 KNo 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work' Division 1 Yes 2 🗌 No Z ☐ Accident3 ☐ Suicide4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital ledical

State Registrar 29a. Certifier

29b. Signature

31. Date filed /M

(Check

3 🗌

MANUN

ad title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANKS

200,

6701

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

OCOURC

MUSUNT

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5. Social Security Number

064-80-1344

Months

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4b. City, Town, or Location of Death

If Under 1 Year | If Under

Days

ever

Year)

4c. County of Death

2. Date of Death

October

State Registrar	Certificate of Death
Decedent's Name (First Middle Last)	

Age In vrs. last birthday

HUBERT

Μ.

Sex 1∭2 M 2 □ F

4a. Facility Name (If not institution, give street and number,

Physician /Medical Examiner

**Funeral** Director

Box 68760 P.0.

10/6/1991 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Madical Examiner must be notified at PRINCE GEORGE'S FT. WASHINGTON Director 10e. Street and Number ō 23a 9106 RIDGEWOOD DR. 20744 Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 □Yes 2 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4or 5+)  $1 \mathrm{Yr}$ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other th any injury or other traumatic event STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES HUBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 772 YVETTE TALLEY ၉ 19a, Informant's Name/Relationship (Type, Print) CHARLES HUBERT/FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donaţion 5 ☐ Other (Specify) CLINTON, RESURRECTION CEM. 10/14/09 21. Signature of Funeral Service L 1425 MARYLAND AVE., pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease. shock, or heart failure. L one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (ar as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by vurs after death, eral Director. After this certificate has been si filled in by the funeral director, page 2 should I 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury
Injury
M

1 2

28c. Injury
M

1 2

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 4 ☐ Homicide 57 reel e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print)

1 XYes 2 ☐ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry EDUCATION

MD.

3. Time of Death

Birthplace (State of Foreign Country)

10d. Inside City Limits

GERMÁNY

1712 M

20c. Location - City or Town, State

22. Name and Address of FacilityCAPITOL MORTUARY DC NE 20002 Approximate Interval Between Onset and Death

> 23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

Year

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 30/

28f. Location (Street and Number or Ru City or Town, State) ral Route Number,

29d. Date signed (Month, Day, Year)

Registrar's Signature

DHMH 17 Rev 1/200

State Registrar

09-07837

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jamal Rashad Hubert

Jamai Nasilau II	1	- For State	Certif	ficate of Deat		ai i iygic	Reg.	No.	DDS	0001
Physicia	n/	Decedent's Name (First, Middle,Last)				M	ate of Death onth D	ay Ye		Time of Death 1
Medical Exami		JAMAL R. HUBERT		14, 67,	Town and analism of		ctober 8, 2	4c. County	of Death	20451115
		4a. Facility Name (if not institution, give stre Northbound Route 202 and W			Town, or Location of er Marlboro	Dealii			George's	
Funeral	4	5. Social Security Number 6. Sex	7. Age (In yrs. last		er 1 Year If Under	r 24Hrs. 8.	Date of Birth(	MM/DD/YYY		lace (State or
Director	- 1	218-35-1573 <sub>1</sub> X <sub>M</sub>	2 F	19 Yrs. Month	ns Days Hours	Min.	11/10	/1989	Foreign Coun	tryGERMANY
	ŀ	Usual Residence of Decedent							- 14	0d. Inside City Limits
w any		10a. State 10b. County		own or Location	TON				1.	1 X Yes 2 No
yland -f sho	ţ	MD PRINCE GE	URGE S FI.	WASHING'	Code		10g	. Citizen of W		-1.
ne Maryland or 28a-f show any fred at once.	Director	10e. Street and Number $9106$ RIDGEWOOD D	R.		744		1	U.S.A		
with th		11. Marital Status 12	Was Decedent Ever in U.S.		ent of Hispanic Orig					n Indian, Black,
leath r	Funeral	1 X Never Married 2 Married	Armed Forces? Yes 2 X No		ify Cuban, Mexican,	Puerto Rica	n, etc.)	Whi	te, etc. BLA	CV
after (	ΡĄ	3 Widowed 4 Divorced If Your Conf.	s, Give Year lates:		No specify:		<del></del>	Specify:		
hours natur Exam		15. Decedent's Education (Specify only hi	ghest grade completed) 1: College (1-4 or 5+)	6a. Decedent's Usual during most of wo	l Occupation (Give lorking life. DO NOT		done 11	6b. Kind of B	susiness/inc	dustry
36 nin 72 than than	Completed	Elementary/Secondary (0-12)	1Yr		STUDEN	JТ		EDHC	ATIO	N
5-00 ed with sygiene other	등	17. Father's Name (First, Middle, Last)	111		18.Mother	s Name (Fire	st, Middle, Ma	iden Surnam	e)	• •
215 be file ntal H rked o	a	CHARLES HUBERT			YVET	TTE T	ALLEY			
MD 21215-0036 d 2 should be filed within 7 d and Mental Hygiene. n 27 is marked other than numaite event, the Medisa	-1	19a. Informant's Name/Relationship (Type,								Zip Code) 20772
, ME and 2 sealth a cem 27		CHARLES HUBERT / FA	IHEK 20b. Pla	8619 TR	UMPSHILI ame of cemetery,	KD.	te :	20c. Location	LBUK 1 - City or T	own, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 I	Removal from State RESU	matory or other place	N CEM.	10/1	4/09	CLIN	TON,	MD.
Itimen ortant		Donation 5 Other Specify:     nature of Funeral Price Licensee	1 1 1		d Address of Facility	CAPI	TOL M	ORTHA	RY	
Ba Perm Perm Imp	1	Marmother	- salley	11425	MARYLANI	) AVE	., NE	WASH	I., D	
Physician		3a. Part I. Enter the disea e, or complicat failure. List only one cause on each li		not enter the mode	of dying, such as c	ardiac or res	piratory arres	t, shock, or h	eart	Approximate Interval Between Onset and
/Medical / Examiner		Immediate Cause (Final disease a. MU	Itiple Injuries							Death
		b	to (or as a consequence of):							
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	to (or as a consequence of):							
	Examiner	(Disease or injury that initiated C.	to (or as a consequence of):							
760, sate be executed physician and he burial - transit		d								
be exe	Medical	UNPENDED	MENDED							
760, ficate b g physic the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	3c. If yes, outcome of pregna		b 3 Ectoni	c pregnancy		23d. Date Month	of delivery Da	ay Year
Box 687 e death certific the attending p	sician/I	past 12 months?	Pregnant at time of deat	_						
P.O. Box 687 that the death certific ned by the attending p detached for use as th	Phys	1 Yes 2 No 9 Unknown		Direction and a first		221	23e Did tob	2000 USB 000	atribute to th	ne cause of death?
that the red by detach	by P	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlyif	ng cause given in Pa	art I.				ably 4 V Unknown
ords, P.C w requires that as been signed to should be deta							24a. Was ar	n 24b		opsy findings available
COFC law re has be	Completed						autops perform	ned?	death?	ompletion of cause of
tal Rection: The certificate ector, page	Co	25. Was case referred to medical		<del></del>	26.Place of Death	(Check only	1 Yes 2	No	1 🗸 Yes	2 No
/ital sician is certi	Be c	examiner? Hosp	oital: 1 Inpatient 2 E	ER/Outpatient 3	DOA Other	Nursing H		Residence 6	✔ Other:	Scene
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the fact death.  All Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month Day Year)	28b. Time of Injury	28c. Injury at World	k? 280	d. Describe he	ow injury occi	urred	ed in motor
ion tendin eath. for: A	ation	1 Natural 5 Pending 2 Accident Investigation		FOUND: 1400 hrs	1 Yes 2 ✔	<sup>∐No</sup> vel	hicle accid	lent		
ivision or Atteno after death Director:	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At hon		ry, office building, e	l l	or Town, Sta	ate)		al Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the		4 Homicide determined	(Specify) Major Road							orse Roa, Upper Ma
24 E E	Medical	one) 2 Medical Examiner: Or	To the best of my knowledge the basis of examination and	e, deatn occurred at t d/or investigation, in t	ne time, date and pl my opinion, death o	ccurred at th	e time, date a	ind place, and	d due to the	cause(s)
To the within To the compl	Med	29b. Signature and title of certifier	d manner stated.		9c. License number					th, Day, Year)
		That WIN	L TO		O.C.M.E.	OCME		October	9, 2009	
		30. Name and address of person who com								
	H/ i	Theodore M. King, Jr., MD.	Assistant Medical Ex		Penn Street, Ba	altimore, I	MD 21201			
S Regis	tate	31. Date filed (Month, Pay, Year) 0 CT 1 9 2009	32. Registrar's Signature	Sare						
Regis	arell.		No.	7		÷	·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** Pamela Kay Johnson 610 7009 OCTOVEY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Seasons Hospice & Palliative Care Baltimore Randallstown If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 M 25F Months Days 56 216-66-4124 Director 11/07/1952 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- " any injury or other traumatic excession." 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 X No Director Middle River Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Chattuck Court 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Balto. Co. Public Sch. Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Howard Shifflett Patricia Taylor ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles C. Johnson (Husband) 9 Chattuck Court, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 10/19/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Euneral Service Licensee 23a. Part 1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi Cause (Final disea or condition res ung in death) **Physician** Stage End /Medical Due to (or as a conse flence of): Examiner Alcono Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes æ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Mother Specified WOSPICE 1 Yes 2 No Other: 4 Nursing Home 5 Residence Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Sitta Registrar

DHMH 17 Rev 1/2001

of Vital Records, P.O. Box 68760

Division

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ton

32. Registrar's Signature

5401

7 RD Randallstrum

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		State of iv	iaryian	,	artment of H rtificate of L		na ivie		gien Reg. N	CAR	9	33315
Physic	ian	1. Decedent's Nam			CONT	7.0			2.	Date of De Month	D		ear	3. Time of Death
/Medi Exami				DAVID JOHN give street and number		JR.	4b. City, Town, or	Location of D	 Death	OCT 1		009 c. County of I	Death	8:47 P M
Exami	iei			MEDICAL C				ETHESDA				MONT	GOM	ERY
Funeral Director		5. Social Security None	Number 6	. Sex 1 M 2 □ F	ige (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours I	Min.	Date of Bir (Month, Da	ıv, Yea	r)	Coun	lace (State or Foreign try) yland
and		Usual Residence of	f Decedent 10b, County		10c. City	y, Town or Lo	cation						10	0d. Inside City Limits
Maryla -f sho	tor	PA	Chester	•		mingto								1 ☐ Yes 2 X No
r 28a	Director	10e. Street and Nu	1	•	BOW	minge	10f. Zip Code				10g. C	Citizen of Wha	t Coun	try?
th wit	la 🗆	227 Talu	cci Driv	7e			19335				U	.S.A.		
ite, intally lated A 12.13-0030 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprairer reast be notified at	y Funeral		ried 2 Marrie	If Yes, Give	? [No		Was Decedent of H If Yes, specify Cuba 1 □Yes 2ሺNo	ispanic Origin in, Mexican, F Specify:	n? (Specif Puerto Ric	fy Yes or No can, etc.)	)-	14. Race - Black, \ Specify:	White, e	etc.
e hours	ted by	3 Widowed	15 Decedent's	Year or Dates Education	:	16a. Deced	dent's Usual Occup	ation			16b.	Kind of Busin		ite
thin 72 ne.	Completed	(Spe	cify only highest	grade completed) College (1-4or	5+)	(Give life. L	kind of work done o	during most of l)	of working					
lled wi Hygier Ther th	Cor	17. Father's Name	0	not)			N/A	18 Mother's	Name (F	irst Middle		A (A Surname)		
d be fi ental li ced of c even	o Be			Johnson, Sr				Bella			, //////	,,, OB,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
e, INICITY Control of and 2 should Health and Merem 27 is marke where traumatic	ပ			(Type. Print) Fath		19b. Mailir	ng Address (Street	and Number	or Rural F	Route Numb	er, City	or Town, Sta	ate, Zip	Code)
and 2 and 2 salth a 127 ls				Johnson, Sr		227 I	alucci D	r., Dov	wning	gtown,				
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra				□ Removal from State	e i		sition (Name of matory or other place Cemetery		Date 0/19/			Location - Cit		
permit. Departm Imports any inju		21. Sign (ture of	uneral Service Li	VIII me	u	22	Name and Address Dellavect 410 N. Cl	ss of Facility Chia Fu hurch S	unera St	al Hom Westo	ne hes	ter. P	A 1	9380
		23a, Part 1, Enter	the disease, or co	omplications that cause only one cause on each	ed the death	n. Do not ent								Approximate Interval Between
Physician		Immediate Cause disease or conditi	(Final on		мотно	RAX								Onset and Death
/Medical Examiner	ı	resulting in death)	4	Due to (or a	s a consequ	uence of):								
	Jer	Sequentially list co if any, leading to in	onditions, nmediate	b Due to (or a	ıs a consequ	uence of):							+	
scuted and transit	Examiner	Cause (Disease of that initiated event	r injury	c				_						
tificate be executed g physician and as the burial-transit	a E	resulting in death)	Last	Due to (or a	s a consequ	uence of):								
rtificate ng phys	edical			d									1	
ath cer attendin for use	sician/M	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □ No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of d	death 3	☐ Ectopic pregnanc ☐ Other <i>(sp</i> ec <i>ify)</i> _	у				23d. Date of Month		ery Day Year
that the dended by the detached	/ Phy			s contributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did	tobacc	o use contrib	ute to th	he cause of death?
w requires s been sign should be	ed by									1 🗆	Yes	2 <b>∑</b> No 3	☐ Prob	oably 4 Unknown
he law re e has ber ge 2 sho	Completed			-					_	24a. Was auto perfe	psy ormed?	prid dea	or to co ath?	psy findings available mpletion of cause of
an: T an: T tifficat tor, pa	a	25. Was case refe	rred to medical					26. Place of	of Death (	1 ☐ Yes Check only	- 10	No   1L	_Yes	2 □ No
nysici nis cer direct	To B	examiner? 1 ☐ Yes 2 ☐		Hospital: 1 💢 inpa	tient 2 🗌	ER/Outpatier	nt 3 DOA Oth	or:				6 □Other	(Specif	(y)
ling Pf	ion:	27. Manner of Dea 1√2 Natural	5 Pending	28a. Date of Ir (Month, L	njury Day, Year)	28b. Time o Injury	Wor			d. Describe	how in	jury occurred		
or Attenctifier death	Certification:	2 Accident 3 Suicide 4 Homicide	investiga 6	the I	njury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office	Yes 2 □ No	-	f. Location City or To	(Street wn, Sta	and Number ate)	or Rura	al Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier (Check only	1 ☐ Certifying 2 ☐ Medical E	Physician: To the bes	of examina	owledge, deat	h occurred at the ti	me, date and opinion, death	place, an	d due to the	e cause	e(s) and mani and place, an	ner as s d due to	stated. o the cause(s)
To the within 2 To the comple	Med	29b. Signature and	title of certifier	and manner :	siated.		29c. Licens	e number			29d. l	Date signed (	Month,	Day, Year)
P S F O		15	- Hal	2 MD			D-00	066475			Oc	r 13,	200	09
3		30. Name and add	lress of person w	ho completed cause of	death (Iten	n 23a) (Type,	MAI.	CONAL 1					R	
	ate	BRTAN 31. Date filed (Moi			F trar's Signa	iture		HESDA N	MD 20	)889-5	600		-	00.00
Regist				6000		1 1	askal							

DHMH 17 Rev 1/2001

### 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** IRVING **JACOBSON** OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST RANDALLSTOWN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 077-16-5673 01-11-1921 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 28a-f show the Medical Examiner must be notified at **Funeral Director** MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 3601 CLARKS LANE, #310 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Š 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **OWNER** RETAIL Department of Health and Mental Hygis mportant: If item 27 is marked other i any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Pages 1 and 2 should be LOUIS **JACOBSON** ပ **FREDA** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM JACOBSON/WIFE <u>3601 CLARKS LANE, #310, BALTIMORE, MD 21215</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State FRANKLIN STREET CEM. 10-16-2009 | ELMIRA, NY 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cell Carcinoma enal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760; Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ CIMONIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown KIDN Completed 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify NS HOSPICE Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier

28b. Time of Injury

27. Manner of Death

1 🔃 Natural

2 Accident

3 ☐ Suicide

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

Month

5 Pending investigation

6 ☐ Could not be

H45931

October 15 2009

3. Time of Death

1210 A

Birthplace (State or Foreign Country)

NY

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ¥ Yes 2 No

Year

2009

14. Race - American Indian,

WHITE

PISETZNER

Black, White, etc.

Specify:

BALTIMORE

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

OLD COURT ROAD Randallston MD Burton 31. Date filed (Month, Day, Year) 32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

State Registrar

within 24 hours aft

To the Funeral DI

completely filled in

09-07877 Alonzo Key

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	I- For State		ertificate of	Death		Reg	. No.	10 0001
Physicia edical Exami	ın/	Decedent's Name (First, Middle, La	st) Alonzo Lee	Key III <del>Key</del>			2. Date of Death Month C October 10,	Day Year	3. Time of Death U
euicai Examii	lei	4a. Facility Name (if not institution, gi		-	4b. City, Town, or Lo	ocation of Death	October 10,	4c. County of Deat	h
		Johns Hopkins Hospital			Baltimore				
Funeral		5. Social Security Number 6. S	, ,	rs. last birthday)	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.	-	(MM/DD/YYYY) 9. Bi Forei	gn
Director			X <sub>M 2</sub> F	26 Yrs			2-8-3	L983 C	ountry) MD
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Locat	ion				10d. Inside City Limits
*	Ļ	MD N/	A E	Baltimor	ce				1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	untry?
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once		717 N. Lakew	ood Avenue		2120			USA	
th with	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ever	n U.S. 13. Wa	as Decedent of Hisp 'es, specify Cuban,	anic Origin? ( Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
er dea			1 Yes 2X N	10	Yes 2X No	specify:		Specify: B.	lack
urs afi turaf	d by	15. Decedent's Education (Specify	or Dates:		nt's Usual Occupation	on (Give kind of w		16b. Kind of Business	/Industry
6 72 ho an "na	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working life. I		rea)		
5-0036 led within 7: Hygiene. other than	duc	llth grade	N/A	Une	employed		(First, Middle, Ma	Unemplo	<u>oyea</u>
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other that natic event, the Med	Be C	17. Father's Name (First, Middle, Las Alonzo Lee Ke	or.		''		Chapma		
2121 ould be fi I Mental I marked ic event,	To E	19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	and Number or F	Rural Route Numb	er, City or Town, Stat	e, Zip Code)
e, MD I and 2 sho Health and item 27 is		Mattie Seller		717		od Ave	nue Ba	alto, MD 20c. Location - City of	21205
ore, M ss 1 and 2 of Health If item 2		20a. Method of Disposition  1 X Burial 2 Cremation 3		crematory or o		- 1			
Baltimore, permit. Pages 1 an Department of He important: If ite		4 Donation 5 Other Specia	fy:		emorial Name and Address				stown, MD
Baltimor permit. Pages I Department of I Important: If		21. Signature of Funeral Service Lice	ensee		llOl E.				MD 21202
Physician		23a. Part I. Enter the disease, or con					_		Approximate Interval Between Onset and
/Medical	3. 3	failure. List only one cause on Immediate Cause (Final disease	<sub>a.</sub> Gunshot Wounds (2	) to Abdomen	and Right Hip				Death
		or condition resulting in death)	Due to (or as a consequent	ce of):					
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):					
7	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):		<del></del>			+
outed nd transit			d	· · · · · · · · · · · · · · · · · · ·					
760, cate be executed physician and he burial - transi	Medical	UNPENDED	X AMENDED#17per	FH,G896,10	0/20/09 <b>,</b> WS	perMe			
3760, ficate b g physic s the bur	J/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy		Ectopic pregna		23d. Date of delive Month	ery Day Year
cath certiff attending for use as	sician/	past 12 months?	4 Pregnant at time	-6-1	Other (Specify)				10
that the death certificated by the attending detached for use as it	Phys	1 Yes 2 No 9 Unknown  Part II. Other significant condition:	9 Otkilowii	not reculting in the	underlying cause d	iven in Part I	23e. Did tol	bacco use contribute	to the cause of death?
P.O s that t gned by	þ	Part II. Other Significant Condition	s contributing to death but	not resulting in the	didenying oddoo g	iron in raice.			robably 4 Unknown
ds, P equires t een sign	Completed						24a. Was a		autopsy findings available o completion of cause of
COF e law r e has b ge 2 sh	mpl				··	<del></del>	autops perform	med? death'	?
Vital Rec ysician: The his certificate director, page	e Co	25. Was case referred to medical			26.Place	of Death (Check			
of Vital Records, ag Physician: The law requir After this certificate has been si neral director, page 2 should b	To B	examiner?  1  Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/Outpatier	ii 3 Dox				her:
n of \ding Phy.  After tl funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Oct 10, 2009	28b. Time of 1306 hrs		y at Work? ′es 2 ✔ No	28d. Describe h Subject shot	now injury occurred	
Division lal or Attendil rs after death. at Director: A	catic	2 Accident 5 Pending Investig					28f. Location (S	Street and Number or	Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could n 4 Homicide determin	ot be		oot, lactory, smoot	unung, oto.	or Town, St 700 N Kenwoo	tate) od Avenue, Baltimo	ore, MD
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wiedge, death occ	urred at the time, da	ite and place, and	d due to the caus	e(s) and manner as s	tated.
To the Hos within 24 h	edical	one) 2 Medical Examin	ner:On the basis of examinat and manner stated.	ion and/or investig			at the time, date a		
0 - 1 - 1	Š	29b. Signature and title of certifier			29c. Licens			29d. Date signed (/ October 11, 20	
		his him,	a annulated a sure	(Itam 22a)		v:		00,000, 11, 20	
	8 G	30. Name and address of person wh Ling Li, MD Assistant			eet, Baltimore,	MD 21201			
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	,,				
Regis	trar	OCT 19 ZUU9	Anoun B.	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Pauline D. Keromitis 2009 <u>a</u>™ 4:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Nursing & Rehab. Ellicott City Howard Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XT Hours 01 / 27 / 192 Country) Director 213-28-1896 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Howard Ellicott City MD 10e. Street and Number 10g. Citizen of What Country? Funeral 12016 Grayton Run 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 XWidowed 4 Divorced Specify: White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmit. Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Mentis Matina Maqulas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Cuzmanes - daughter 12016 Grayton Run Ellicott City, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Ortho, Cemetery 10/17/2009 Woodlawn, MD Sig / ture of Fundral Serving Liven ee 22. Name and Address of Facilit Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Filysician/ Atherosclerotic Cardiovascular Disease Medical resulting in death) Examiner Advanced Dementia Sequentially list conditions, Examine cause. Enter Underlying Due to for as a sonsequence of, Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🕱 No 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform hours after death.

Inneral Director: After this certificate I 2 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination and/or investigation, it my opinion, years a social and all a social and the to the cause(s) and manner as stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sabapathi 201-109 Back River Neck Road

32. Registrar's Signature

29c. License numbe

D30641

Baltimore, MD

29d. Date signed (Month, Day, Year)

October 16, 2009

21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month 2009 /Medical Facility Name (If not institution, give street and rumber) 4b. City. Town, or Location of Death 4c. County of Death Examiner Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG. 18,1920 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 😿 F MARYLAND 216-10-7673 89 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience in ust be notified at Director 1 ☐ Yes 2 ☐ No MD HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 WOODHOME DRIVE 21015 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Itimore, Maryland 21215-6036 1 ☐ Yes 2 🔀 No Specify: \$ Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other trannatic event, Ite Medical Exa 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN POLISZUK P PAULINE LEWKO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIM KANY/ SON 1810 WOODHOME DRIVE, BEL AIR, MARYLAND 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MICHAELS UKRAINIAN 10/16/09 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facilities INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bursh-transit completely filled in by the funeral director, page 2 should be detached for use as the bursh-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No Heart 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2. No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my principle death. 29a, Certifier Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of confifie 29c. License number 29d. Date signed (Month, Day, Year) D 006398 M.D. 2009 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Y. Lee, MD 669 Revolution St. Havre de Graco 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Talis Felei Kiaillei	1-For State State of Maryland / Department of H		Reg. No.						
Physician/	1. Decedent's Name (First, Middle,Last)	2. Dat	e of Death	3Time of Death					
Medical Examine	HANS FEIER KRAFIER	Oct	ober 10, 2009  4c. County of Death	0851 hrs					
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Funeral			ate of Birth (MM/DD/YYYY) 9. Bir						
Director	216-44-1584 1XM 2F 63 Yrs.	Months Days Hours Min.	CT. 26,1946 Co	untry) GERMANY					
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
				1 Yes 2 No					
the Maryland a or 28a-f show tiffed at once.	10e. Street and Number 10	of. Zip Code	10g. Citizen of What Cou	ntry?					
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland feelih and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3101 . CARDINAL WAY APT F	21009	USA						
er death with t	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was D 14. Was Decedent Ever in U.S. 15. Was D 16. Yes,	ecedent of Hispanic Origin? ( Specify Y specify Cuban, Mexican, Puerto Rican,		ican Indian, Black,					
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	KARL H. KRAMER, SR.	GRETEL MA							
MD 21215-00; d.2 should be filed within and Mental Hygene. m 27 is marked other thannatic event, the Mecannatic event		dress (Street and Number or Rural R		e, Zip Code)					
ore, MC is I and 2 si of Health ar If Item 27 ier trauma	20a. Method of Disposition 20b. Place of Disposition	(Name of cemetery, Date	PPA, MD 21085 20c. Location - City or	Town, State					
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int. If Item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Burial 2 X Cremation 3 Removal from State crematory or other 4 Donation 5 Other Specify: ATLANTIC C		09 GLEN_BUR	NIE MD					
Baltimore, ME permit. Pages I and 2 s Department of Health as Important: If Item 27 injury or other traum			ER-DIPPEL FUNER						
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Physician /Medical	failure. List only one eause on each line.	iodo or dynig, oddir do odraido or roopii	atory arrows, or mount	Between Onset and Death					
xaminer	Immediate Cause (Final disease or condition resulting in death)  a Intra-oral Gunsnot Wound  Due to (or as a consequence of):								
5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			1					
nd ransit	events resulting in death) Last  Due to (or as a consequence of):  d.								
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b. Box 687 the death certific by the attending p ched for use as the	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  Yes 2 No 9 Unknown  G Unknown								
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Division of Vital Records, P.O. tat or Attending Physician: The law requires that the rs after death.  "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	•	, , , , , , , , , , , , , , , , , , ,	1 Yes 2 ✔ No 3 Pro						
cords, P law requires t has been sign t 2 should be c				utopsy findings available completion of cause of					
Records, The law require, freate has been sig, page 2 should be			performed? death?  Yes 2 No 1 Y						
Ital Rician: Tician: Ticetor, p	25. Was case referred to medical	26.Place of Death (Check only or							
f Vid Physic er this cal dire	1 V Yes 2 No 1 Inpatient 2 ER/Outpatient 3		e 5 Residence 6 Other Describe how injury occurred	er: Scene					
on on on on on on on on the function:	1 Natural 5 Pending Pound: Pou		ect shot self						
VISIC or Atte fter des Directo in by the	2 Accident Investigation Oct 10, 2009 0851 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, 1		ocation (Street and Number or R	ural Route Number, City					
Division of Vital Rec Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate I rely filled in by the funeral director, page	4 Homicide determined (Specify) Woods	3101	r Town, State) Cardinal Way #F, Abingdon,	MD					
To the How within 24 h To the Fun completely		at the time, date and place, and due to in my opinion, death occurred at the ti	the cause(s) and manner as sta me, date and place, and due to t	ted. he cause(s)					
Son Son Series	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo						
	my an, no	O.C.M.E.	October 11, 200	9					
101/	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 21201							
State		A D		<u>.</u>					
Registra									
Dirling 17 Rev 1/200	ORIGINAS		OGME						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #30 Per ANA BD C895 10/16/09 Jh

amend #9,15,16a,17,18&19a&b Per ANA BD C896 Mental Hygine

Certificate of Death

Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 4a. Facility Name (If not institution, give street and number) 948 PM 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of mayland medical Center Universit If Under 1 8. Date of Birth (Month, Day, Dec 2, Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Months Days Hours unk Director 52 1956 219-74-2716 **Maryland** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "naturar", or items 23a or 28a-f show <sup>10a. State</sup> unk la or 28a-f show 10b. County unk unk 10c. City. Town or Location 10d. Inside City Limits Director unk □Yes 2 □ No unk | 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a Even incrust USA Funeral 12. Was Decedent Ever in U.Sunk
Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify. white Specify: 3 ☐ Widowed 4 ☐ Divorced Completed unk event, the Medical 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 8 0 construction unk 17. Father's Name (First, Middle, Last) 1111K 18. Mother's Name (First, Middle, Maiden Surname) Be George Chester Knapp Peggy Lee Chenoweth ပ other traumatic 3242 in Kittigs Trey and Number Rural Brid Number of Jun Siz 1229 de)

- 22 S. Greene Street Baltimore, MD 21201 19a Patricia Name/Belationship (Type Priet) University of Md Medical Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If it any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Ronald e Licensoe State Anatomy Board 655 W. Baltimore Street Mreetor 21201 Baltimore, MD 23a. P. t1. Enter the in ease, in conf shick, or heart failure. List only r completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or ition resulting in death) **Physician** Due to (or as a consequent e of): /Medical Examiner ue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner pital or Attending Physician: The law requires that the death certificate be executed ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1€ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1023224281 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Holcren University of Maryland Medical Center Baltimore ,MD 31. Date filed (Month Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ochober 15, 2009 Walter Kopczynski 11:45PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. Hours Sept17, 1930 79 Director 215-24-0401 Mary'land Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? must be r Funeral 2310 Cambridge Street 21224 U.S.A. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner rmed Forces Black, White, etc. þ 1 XNever Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 - Widowed 4 - Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8 t h College (1-4 or 5+) Longshoreman I.L.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter J. Kopczynski Elizabeth Struzykowski permit. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OCTOBER <u>Monica Skarpac (sister)</u> 2310 Cambridge Street Baltimore, Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla St.Stanislaus 1 K Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cem 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, P.A Avenue Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending X Natural work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	,,,,	Ce	rtificate of E		, ,	g. No. 2 0 0 0	33323	
	Physici	an	1. Decedent's Name (First, Middle, La	ŕ	<del>, , , , , , , , , , , , , , , , , , , </del>			2. Date of Death Month	Day Year	3. Time of Death	
1	/Medic		Mary Lee  4a. Facility Name (If not institution, given			4b. City, Town, or	Location of Death	Octobe	16, 2009 4c. County of Dear		
-900	, Examin	e	Long View Nurs	,			hester		Carrol1		
	Funeral Director		212-30-5899	Sex 7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 2,	9. Bir 1921	thplace (State or Foreign ountry) NJ	
	land		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits	
	Mary a-f sh	tor	MD Carrol	1	Mar	nchester				1 □Yes 2 □ No	
	or 28:	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?	
	s 23a		3332 Main Str			211			USA		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the fireful Evanter must be notified a once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 【 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 □Yes 2√□ No	sp <i>a</i> nic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W		
15-0	n 72 ho "natur	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Dece	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of work	ing 1	6b. Kind of Business/	Industry	
212	d withi	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		ietician's			Food Se:	rvice	
nd	be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Last					e (First, Middle, M			
<u> </u>	hould d Men marke matic	욘	•	an Severen	405-14-15		Jean I				
, Ma	and 2 sealth an 27 is i		Mrs. Betty J. Ma	**					City or Town, State, 2		
Baltimore, Maryland 21215-0036	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Inemoval form State		sition (Name of natory or other place ty Cremat:			Oc. Location - City or Sykesville		
Balt	permit. Departimont any inj	2 8	21. Signature of Funeral Service Lice	Jaight Moo	764 H	AIGHT FUN O Box 195	ERAL HOMI Sykesvil	E & CHAPE	EL, P.A. 21784		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de						Approximate Interval Between	
6	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Preumor	lla					Onset and Death	
1	/Medical Examiner		Toolaking in double	Due to (or as a conse	equence of):						
	B +	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):						
	ecuter and transi	Examiner	cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last	c							
60,	icate be executed physician and the burial-transit		and a second sec	Due to (or as a conse	equence or):						
68760	tificate ig physas the	Medical		d							
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/IV	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)							
σ.	that the		Part II. Other significant conditions	ontributing to death but not re	esulting in the ur	nderlying cause giver	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
rds,	w requires to been signer should be a	ed by						1 □ Yes	s 2 1 No 3 □ Pr	obably 4 ☐ Unknown	
Vital Record	e a p	Completed						24a. Was an autopsy perform	prior to o	ntopsy findings available completion of cause of	
/Ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deatl	1 □ Yes 2 n (Check only one		2 □No	
0	ding Physi h. After this c funeral dire	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatien		4 Mursing Ho		nce 6 □ Other (Spe	cify)	
0	th. : After	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	Injury	Work?	es 2 🗆 No	28d. Describe how	v injury occurred		
Division of	To the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director; After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined		home, farm, stre cify)	eet, factory, office		28f. Location (Stre City or Town,	tion (Street and Number or Rural Route Number, or Town, State)		
	To the Hospit within 24 hours To the Funera completely fille	Medical (	29a. Certifier (Check only one)  1 ☑ Certifying Pr 2 ☐ Medical Exam	nysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, death	n occurred at the time vestigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)	
•	To the within to the complete	Me	29b. Signature and title of certifier,	HMD		29c. License	number 43375		d. Date signed Month	h, Day, Year)	
•	Q V		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, I	Print)		, MD 21			
*	≬ V Sta	e	31. Date (1907) 0/11, (24) 26 19	32. Registrary Sign		0					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 19, 2009 James Leutner, Jr. 3:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Heritage Nursing Center Dundalk If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07/29/1935 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 □ F 213-32**-**6822 74 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination in the notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director Maryland Baltimore 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4128 Raymonn Avenue 21213 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status XXYes 2 No 1952− If Yes, Give Year or Dates; 1958 Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 🗙 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Black and Decker <u> Machine Operator</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis James Leutner, Sr. Margaret Gay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Helen Baker (Sister) 9 Kerra Lane, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 10/22/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Estar the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Imme in e Cause (Final dise in e or condition resulting in death) CONGESTIVE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine or Attending Physician; The law requires that the death certificate be executed CORINARY use as the burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signi page 2 should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 **DX**0 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.0.

Records,

of Vital

Division

32/Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 19, 2009

Assistant Medical Examiner

32. Registrar's Signature,

30. Name and address of person who completed cause of death (Item 23a)

OCME

Carol Allan, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Albert 15,2009 7:31pM Moran October /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Arundel

9. Birthplace (State or Foreign Country) Annapolis Anne 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 1 / 19 / 1924 **Funeral** 1**∑**M 2□ F Months Days Hours Min 85 217-14-9510 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits if than "natural", or items 23a or 28a-f shov the Medical Evaniner πust be notthed at Director 1 ☐ Yes 2 ☐ No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Chatham Court 1451 Funeral 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No . Specify: ģ Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than "any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Electrician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph T. Moran Emma J. Rapp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Moran / Daughter 1451 Chatham Court, Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 10/20/2009 | Elkridge, Maryland Begation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 XNo 1 ☐ Yes 2 D No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C TS certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 30. Name and address of person completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene

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500	401		-					

Physician
/Medical
Examiner

**Funeral** Director r 28a-f show notified at "natural", or items 23a or dical Examiner must be

1 and 2 should be filed within 72 hours after death with the Maryland the Medical al Hygiene. other than ' Is marked of Pages 1 and 2 nent of Health annt. If Item 27 Is y or other the permit. Page Department o Important: If any Injury or

Baltimore, Maryland 21215-0036

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 this

funeral Hospital or Attending after death Director: filled in by Funeral соmpletely within 2.

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Day Month October 10, 2009 12:30 AM L. Marshall 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Manor Care - Potomac Potomac Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (State (Month, Day Year) | Miami, FL 5. Social Security Number 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 1XM 2□ F 84 191-18-2223 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 642 Blossom Drive 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Naval Contracts Naval Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Clinton Marshall Barbara T. Unger 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann Marshall (Wife) 642 Blossom Dr., Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Queen of Peace Cem. 10/17/09 4 Dopation 5 Other (Specify) Hawley, PA 21. Sign ure of funeral Service Licensee 22. Name and Address of Facility
John F. Glinsky Funeral Home 445 Sanderson St., Throop, PA 18512 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Advanced Lung Cancer /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 X Natural 1 Tes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054566 October 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, MD 9801 Georgia Ave. #1-17, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001

		1 - State Registrar	Ce	rtificate of	Death	Re	g. No.		
Diversity in		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
Physici /Medic		Reggy Massey				10		2007	1:39 4
Examin		4a. Facility Name (If not institution, give speet and number)		4b. City, Town, o	Location of Death		4c. Count		
		Shock Trauma Cent		By/t	incre			N/A	
Funeral		1□M 2F7E	rrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Coun	lace (State or Foreig
Director		215-32-3644 Usual Residence of Decedent	75 Yrs.			Oct 14,	1934	west	<u> Virginia</u>
Mo Til			City, Town or Lo	ocation				11	0d. Inside City Limit
ir realin and Meellat hygene. Item 27 is markad other than "naturel", or items 23a or 28a-1 show other traumatic event, I'm Medical Examinar must be notified at	to	Maryland N/A	Baltin	nore					1X Yes 2 □ N
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or its	Ī	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes ※☐ No	Specify:	nican, etc.)		re Whit	
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thert int, th		47 February Name (First Middle Local)	Nur	se	18. Mother's Nam	- /First Middle A	Nursi		ne
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any ir		21. Signature of Funeral Service Licensee Thomas Gre	gor	2. Name and Addre remation 99 Freder	Šociety o	of Maryla	and, I	nc.	1 01000
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		shock, or heart failure. List only one cause on each line.				or roophatory and	,,,,		Interval Between Onset and Death
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S 5	ToE	examiner?  1 2 Yes 2 No  Hospital: 1 Inpatient 2	2 C ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing Ho	me 5 🗆 Reside	nce 6 🗆 Ot	her (Specif	y)
96		27. Manner of Death 28a. Date of Injury  1 Natural 5 Pending (Month, Day Year	28b. Time of	of 28c. Injur Wor	y at k?	28d. Describe ho	w injury occu	rred	
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e Funeral D	edicai	29a. Certifier (Check only 2 Medical Exeminer: On the basis of exam	knowledge, deal	th occurred at the tir	ne, date and place,	and due to the ca	ause(s) and mate and place	anner as si	tated. the cause(s)
To the Fur completely	edi	onel and manner stated							
To	Σ	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date sign		Day, Year)
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		30. Name and address of person who completed cause of death (	Item 23a) (Type	Print)	,				
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Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Si	225 gnature		5+. B.	140.,	WP	21	201

-07952 eorge Peter Me	entis	State of Maryland / Department of Health and Mental Hygiene
	1	1-For State Certificate of Death Reg. No. 12 U U D J J J J J J J J J J J J J J J J J
Physicia edical Exami	ın/	1. Decedent's Name (First, Middle, Last)  George Peter Mentis  1. Decedent's Name (First, Middle, Last)  Month Day Year October 13, 2009  1. Decedent's Name (First, Middle, Last)  October 13, 2009
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Baltimore City
Funeral		Millione 24Hz 9 Date of Birth/MM/DD/YYYV 9, Birthplace (State or Foreign
Director		5. Social Security Number 217–18–6700 6. Sex 1. X M 2 F 85 Yrs. 17. Age (In yrs. last birthday) Months Days Hours Min. January 20,1924 Maryland
, h	ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
d now any		Maryland Baltimore City Baltimore
ie Maryland or 28a-f show <u>ffed at once,</u>	왕	10e. Street and Number 1368 Sherwood Avenue 10f. Zip Code 21239 10g. Citizen of What Country? United States
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene, item 7: is marked other than "natural", or item 23a or 28a-f she remannatic event, the Medical Examiner must be notified at once		13 Was Decedent Ever in U.S. 13 Was Decedent Origin? (Specify Yes or No-
death v or item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
s after ıral", c	ह	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15b. Rind of Business/Industry  15b. Decedent's Education (Specific only highest grade completed) 15a. Decedent's Usual Occupation (Give kind of work done)  16b. Kind of Business/Industry
72 hour	eted	during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4 or 5+)
0036 within iene.	Comple	12 Office Worker Factory  13. Mother's Name (First, Middle, Maiden Surname)
21215-0036 21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	Peter George Mentis
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Highen. In Inportant: If I frem 27 is marked other than "natural injury or other traumatic event, the Medical Examin	To	19a. Informani's Name/Relationship (Type, Print)  Connie D. Bauer/ Niece  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  8424 Waterstreet Road Walkersville, Maryland 21793
e, M 1 and 2 Health item 2		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State
MOF Pages nent of ant: If		Metro Grematory 2009 Baltimore, Maryland
Baltimore, permit. Pages I an Department of Hea Important: If ites	V b	21. Some and Address of Facility Cremation Society of Maryland, inc. 299 Frederick Road Baltimore, Maryland 21228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interve Between Onset and Death
ılıL⊸i⊏al ∢aminer	FY 77	Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):
	1	Sequentially list conditions, b.
	niner	if any, leading to immediate  cause. Enter Underlying Cause (Disease or injury that initiated
cuted and transit	ical Examiner	events resulting in death) Last  Due to (or as a consequence of):  d.
a a exe	dical	UNPENDED AMENDED
8760, ifficate be ng physici	] Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Ox 687 eath certific	Physician/Med	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown
that the dated by the detached	Phy (	
S, P.C uires that n signed l	1 5	
cords law req has bee	Completed	autopsy prior to completion of cause of death of cause of the performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Rec i: The	ြင်	
Vital ysician his cert	To Be	examiner? Hospital: Inserting 2 FR/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 ✔ Other: Scene
J of Jing Ph	l ii	
ision - Attender death	ficati	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cor Town, State)
Div Spital or	Certification:	Suicide 6 Could not be determined (Specify)  Homicide (Specify)  On Outford
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial of the formeral director page 2 should be detached for use as the bun.	Medical	
E BE	N S	OCME October 14, 2009
		ault
_		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	Stat	
Reg	stra	TI UCITY COURT OF THE PROPERTY

DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mary		artment of F			/ / / / / /	8 3 3 3 1
			Registrar  1. Decedent's Name (First, Middle, La	ast)		Tilloate of I	Deam	2. Date of Deatl		3. Time of Death
	Physici		David Dwa	,	Nea	1		Month October	Day 13, 2009	4:20 A M
-	/Medic Examin		4a. Facility Name (If not institution, gi		1100	4b. City, Town, or	Location of De		4c. County of De	
			Laurel Regional	Hospital		Laure1			Prince G	eorge's
	Funeral			· M· · · · · ·	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	lin. 8. Date of Birth (Month, Day, Feb. 2,	Year) 9. B	irthplace (State or Foreign Country)
	Director		232-92-5935	1MM 2LIF 54	Yrs.			Feb. 2,	1955 We	st Virginia
	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ţo	MD Prince	Coomania	T 1					1 ☑ Yes 2 ☐ No
	r 28a	Director	MD Prince  10e. Street and Number	George's	Laurel	10f. Zip Code		10	ng. Citizen of What C	Country?
	th with		14609 Phillip C	ourt		20708			USA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No- uerto Bican, etc.)	14. Race - An Black, Wh	nerican Indian,
36	or it	by Fu	1 Never Married 2 Married	1 ⊟Yes 2 → No If Yes, Give		I□Yes 2⊠No		,	Specify: B	,
00	hours tural"	q pe	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Dooo	tant's Hauel Occur	otion			
5	in 72 "nai	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of v	working	16b. Kind of Busines	s/maustry
212	with jiene. r than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		ibution N	•		Retail	
ρ	al Hyg othe	BeC	17. Father's Name (First, Middle, Las.	1)				Name (First, Middle, N		
/lai	uld bu Menta	은	Joseph E. Neal				Fran	ces M. Han	sbury	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	g Address (Street	and Number or	Rural Route Number,	City or Town, State	. Zip Code)
≥,	and lealth m 27 her tr		Paula Pannell Ne					Laurel, M		
ore	ges 1 if ite or ot		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Dispo	sition (Name of natory or other plac 1	ce)	Date 2	20c. Location - City of	r Town, State
Ξŧ	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Speci		Greenwood Memorial	Park			Beckley, W	
Ba	permi Depa Impo any Ir		21. Signature of Fuheral Service Lice	nsee				St., Beckle		meral Parlor 801
			23a. Part 1. Enter the disease, or con	pplications that caused the					•	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Acute Myo		nrarctio	n			20 Min
	Examiner			, Cardiac I						1 Hour
1,0	p ti	iner	Sequentially list conditions, if any leading to finite dialectories. Enter Underlying Cause (Disease or injury	Due to (or as a co						
Ng.	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Coronary Due to (or as a co		sease				5 Years
8760,	icate be executed physician and s the burial-transit			Due to (or as a co	risequerice oi).					
687	ficate phys s the	edical		_ d						
Box (	leath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of d	elivery
œ.	death e atte	icia	in the past 12 months? 1 □Yes 2 □No	1 Live birth 2 4 Pregnant at tim		Ectopic pregnancy Other (specify)	у		Month	Day Year
P.O.	at the by th tache	Physician/Me	9 🗆 Unknown	9 Unknown				19		
Ś	uires that the de signed by the a d be detached fo	by F	Part II. Other significant conditions	contributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.			to the cause of death?
ord	requir een s rould	ted		-				_ 1 □ Ye	s 2∭ No 3∏	Probably 4 Unknown
ခွ	has b	Completed						— 24a. Was ar autops	24b. Were prior to	autopsy findings available completion of cause of
a F	n: The icate r, pag							perform 1 ☐ Yes 2	ned? death? Mino 1 □ Ye	s 2 No
V.E	siciar certif	Be	25. Was case referred to medical examiner?	Hospital:	V	t 3 🗆 DOA Othe	ori	Death (Check only one	•	
Division of Vital Records,	Physer this aral di	Ę.	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpatient	28b. Time of	1 3 LI DON	4 🗀 Nursin	g Home 5 Reside		pecify)
ion	nding tth. :: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	ar) Injury		ć? Yes 2 ∐No		,.,	
<u>×</u>	Afte er dez ectol by th	lific	3 Suicide 6 Could not be determined		At home, farm, stre	eet, factory, office	1007	28f. Location (Str City or Town	reet and Number or i	Rural Route Number,
Ö	tator rs afte al Dir led in	Certification: To	4 Dronnoido	building, etc. (c	,pccny)			Chy of Your	, State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1	hysician: To the best of m miner: On the basis of exa and manner stated.	amination and/or in	n occurred at the tir vestigation, in my o	me, date and pl pinion, death o	lace, and due to the ca occurred at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To th Withir Comp	Me	29b. Signature and title of certifier	11.		29c. License	e number	29	9d. Date signed (Moi	nth, Day, Year)
			1/1/2011			-04	5928	(	October 1	3 2009
	10		30. Name and address of person who		(Item 23a) (Type,		, ,			2076-
	10			reblue L	RITED	7300	Van Du	sen Rd., I	aurel, MD	20/0/
	Sta Registr	_	31. Date filed (Month Day, Year) 20	09 Leneus	oignature Ac	Red				

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** NOSISM 00 amon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 591 nosp Landulls town Warthure H Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1√ M 2□ F Director Apr 19, 1955 Maryland 214-68-3604 54 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 28a-f show ral", or items 23a or 28a-f shov Examirer reast be notified at Yes 2 □ No Director **Baltimore** Maryland Baltimore with the 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number U.S.A 1903 Park Place 21207 Funeral death v Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. In the firem 27 Is marked other than "natural", or liter any or other than marked other than any or other traumatic event, fire ficalizat Experimany or other traumatic event, fire ficalizat Experimany. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☑ No Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A S Midway Bus Company Office Administrator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelvn Smith Jerry Nelson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1903 Park Place Baltimore, Maryland 21207 Evelyn Smith 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 10/15/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Calvary Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service, P. A. 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final HSCV **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the buria Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Day Year Month 5 Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 N 2 No 1 ☐Yes 1 □Yes After this certification funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ne 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: d in by the i 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed n 24 hours **af**t e Funeral Di eletely filled in within 2 **To the** I

29a, Certifier

Medical

te of certifier 29b, Signature and

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[9] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

andals then

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 LUVT 01 01

31. Date filed (Month\_Day, Year)

32. Registrar's Signature

10

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year NETHKEN 10 CHARLES PM 1250 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE AFNES HOSPITAL 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 XM 2 □ F Yrs. 216-32-9273 73 1935 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No. Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1805 Colonial Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Exterminator Pest Control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles William Nethken, Sr. Catherine McTague 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Nethken Wife 1805 Colonial Road; Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Atlantic Crematory 10/20/2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Seppice License 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PHEUMONIA HRS disease or conditior resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1∏Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

Director

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Completed

Be

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MD

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evandrer must be realised at

72 hours after

should be filed within and Mental Hygiene.

item 27 i

Pages 1 Department of Important: If its any injury or o

Baltimore, Maryland 21215-0036

and attending physician for use as the burial peen has certificate this

Attending

0

Physician/Medical signed by the a ģ Completed Be Certification: To neral Director: / in 24 hours
of the Funeral Discompletely filled Medical

1 Tes 2 No

27. Manner of Death

1, Matural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a, Certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OM A . VITBERF

5 Pending investigation

6 Could not be

determined

206 CATON AVENUE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D64307

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

062

2009 OCTOBER 16

32. Registrar's

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated

2 ER/Outpatient 3 DOA

28b. Time of

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 9:40 AM uina 10 2009 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Renaissance Gardens Baltimore Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Feb. 17, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** New York 1 □ M 2 🗓 F 131-14-5262 Yrs. Director 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ima Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 707 Maiden Choice Lane 21228 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Textiles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Quirin Quina Germaine Gilson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Weinkam, Sr. Personal Rep 1002 Frederick Road; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Cemetery 10/22/2009 Pinelawn, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License MD 21228 1630 Edmondson Avenue; Catonsville, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Stuge Unddisease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes 2 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D44377 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowlin Deneen 711 Maiden MA 31. Date filed (Month, Day, Year)
OCT 1 9 2009 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records.

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RACHANOW 230 AM 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Assisted Oak Lodge Anne Arundel Pasadena 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Hours Min (Month, Day, Year) an 4, 1921 432-62-3959 88 Germany Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21054 USA 831 Freeland Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Industry Key Punch Operator should be filed with and Mental Hygiena is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Freida Pheutzer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Henry Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Tomczak, Daughter Freeland Court Gambrills, Maryland 21054 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/16/09 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service Lions e Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ End Stage Serile Dementia disease or condition resulting in death) reak Medical Due to (or as a consequence of) Examiner Lower extremite Celluliti ts Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Stasis Dormatitiz the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibrillation Dedenerative Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Hypertension has page 2 : autopsy death? certificate 2 No 2 No 1 Tes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Assisted Livina 1 Yes 2 🕨 No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to d in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Month. Day. Year) 052544 ee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #204, Catonsville MD 100 Beutaum M.D. teine 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER **Physician** Ĩ3 12:30 P M GILBERT V RUBIN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 3402 LABYRINTH ROAD BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/09/1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 215-28-8540 89 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, If a Marical Examinating and 1 X Yes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21215 3402 LABYRINTH ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) EXECUTIVE DIRECTOR BALTIMORE ZONING BOARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUBIN FANNIE SIMON KNIPMAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIFRA RUBIN / WIFE 3402 LABYRINTH ROAD, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI 10/15/2009 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) preumom Assiration /Medical Due to (or as a consequence of): Examiner voneting Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conse ence of): Examiner dementia and burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760 certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? The law requires that the death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 【No 3 ☐ Probably 4 ☐ Unknown disorder Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 🕽 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After thi funeral ( 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural 1 ☐ Yes within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1' Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 10/14/09 019914 mpleted cause of death (Item 23a) (Type, Print) 30. Name and ad m d 1. mo 10753 Felle Kd 31. Date filed (Month 32. Registrar's Signature State Darko Registrar

09-08028 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Janet Sterner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 15, 2009 1600 hrs Medical Examiner Janet Sterner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore St. Agnes Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number if Under 1 Year If Under 24Hrs. **Funeral** 6. Sex 7. Age (In yrs, last birthday) Months Days Hours Director Country)MD 212-60-1050 54 2/19/1955 1 M 2 XF Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 X No 28a-f show MD Baltimore Catonsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 510 Kent Ave. 21228 TISA items 23a Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notimore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hours after death wit treen of Heath and Mental Hygiene.
Transt. If Item 27 is marked other than "natural", or items? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Armed Forces? Yes 2 X No Specify: White Yes 2 No specify: Widowed Divorced Give Yea ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bartender 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roger L. Hambrick
19a. Informant's Name/Relationship (Type, Print) Bettv Frank

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Kent Ave., Catonsville,
20b. Place of Disposition (Name of cemetery, Date Betty Roseberry / Mother MD 21228 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from Stat Shepherd Cemetery 10/21/2009 Ellicott City, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Harry H. Witzke's Family FH, Inc. M01411 out 4112 Old Columbia Pike, Ellicott City. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart proximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner ause. Enter Underlying Cau (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical XUNPENDED AMENDED 23a, PII, 27, permE, g897 11/16/09 TT attending physician or use as the burial -Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 ✔ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 V Unknown Asthma, chronic obstructive pulmonary disease: Completed 24a. Was an 24b. Were autopsy findings available pulmonary hypertension prior to completion of cause of autopsy certificate has performed? death? 1 🗸 Yes 2 No Yes 2 he Hospital or Attending Physician: Ti in 24 hours after death he Funeral Director: After this certifica pletely filled in by the funeral director, pa 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 ✓ Inpatient 2 Other, Nursing Home 5 Residence 6 DOA ER/Outpatient 3 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier

completely

Medical

State

Registrar

29b. Signature and title of certifie

Melissa Brassell, MD 31. Date filed (Month, Day Year)

ULI

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.F.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Dav, Year)

October 18, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physicia	n/													3. Time of Death
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		4a. Facility Name (if not institutio 17602 Potter Bell Cou		umber)			21					ic. County of <b>Washing</b>		
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday	) If L	Under 1 Year If Under 24Hrs. 8. Date			8. Date of Bi	ate of Birth(MM/DD/YYYY) 9. Birth			
Director		216-78-2850	1 <b>X</b> M 2 F	35	5	Yrs. Mo	nths Days	Hours	Min.	Feb.	1.	1974		ryland
		Usual Residence of Decedent							L					
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faryla 28a-f Lator		10e. Street and Number		L		10f.	Zip Code			10g. Citizen of What Country?				ry?
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ral",	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No spec											Specify:		ite
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d with	틹	17. Father's Name (First, Middle,	Last)			-			Name (	First, Middle,			CIIS	truction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Larry A.								J. Bo				
21. 21. 21. 21. 21. 21. 21. 21. 21. 21.		19a. Informant's Name/Relations			19b. Ma	iling Addr	ess (Street						, State,	Zip Code)
MD and 2 sho alth and m 27 is aumati	1	Larry A. Smith	n/ father		100:	20 Di	ablin B	Rđ.	M	alkers	svi.	lle, M	ID 2	1793
nore, MD 21215-0036 gges I and 2 should be filed within 72 nt of Health and Mental Hygiene. It: friem 27 is marked other than "other traumatic event, the Medical	Ī	20a. Method of Disposition			b. Place of Dis crematory or	position (	Name of ceme	etery,		Date	20c	. Location -	City or 7	own, State
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Maryland Washington    Hagerstown								Hart	rtzler Funeral Home					
E P P E	-	(attractive C. Main St. Woodsboro, MD 2179)										8		
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/Medical =xaminer	ı	Immediate Cause (Final disease	1-4	hotgun Wo	ound									Death
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8760, tiffcate be ng physicias the buri	<u>⋛</u>  2	IF FEMALE: 3b. Was decedent pregnant in th		outcome of pr		Fetal dea	ath 3	Ectopic p	oregnand	cv	23	3d. Date of one Month		ay Year
Box 6 cath cert the attending of for use a		past 12 months?  1 Yes 2 No 9 Unk		nant at time of		Other (S				_				
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	b.	Part II. Other significant conditi	ions contributing	to death but no	ot resulting in th	ie underly	ring cause giv	en in Part	I.					he cause of death?  ably 4 Unknown
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Division pital or Attendiours after death. leral Director: Afilled in by the fu	Certification:	deter	a not be	Single F	t home, farm, s	treet, tact	ory, office but	ilaing, etc.		or Town,	State)			al Route Number, City
0 - 2 2	- 1	4 Homicide 29a. Certifier	nysician: To the be			eurrod at	the time date	and plan		7602 Potter				
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the		(Check only 1 Certifying Phone) 2 ✓ Medical Exar	miner:On the basis	of examination	-									
S. W. T. S. Con Con Con Con Con Con Con Con Con Con	활	29b. Signature and title of certifie	and manner	stated.			29c. License	number			29d	. Date signe	d (Mon	th, Day, Year)
		auoD.					O.C.M	.E.			00	tober 9, 2	2009	
		30. Name and address of person	who completed cau	se of death (It	em 23a)									
	Ť		istant Medical		•	Street	, Baltimor	e, MD 2	1201					
Sta	_	31. Date filed (Month, Day, Year)	32. F	gistrar's Sign	ature	9 10	9							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year Physician 08 03:25 AM October 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N SINA HOSPITIAL OF BALTIMORE BALTIMORE CITY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Dec. 12 9. Birthplace (State or Foreign **Funeral** Days Country) an 1 M 2 F Months Hours Min 212-36-6320 75 Mar Director Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits Ħ Maryland 1 Nes 2 No other traumatic event, the Medical Exeminer must be notified Directo 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 3107 varrison 23a Funeral "natural", or items 12. Was Decedent Ever ju U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black White etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ Mo 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Restauran marked other than Elementary/Secondary (0-12) College (1-4or 5+) COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Creorge Lee Lowise Adams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rungl Route Number, City or Town, State, Zip, Code) of Health and item 27 is n daughter Vernon Ave 6602 Mt. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State permit. Pages 1 Department of F 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or Man 4 ☐ Donation 5 ☐ Other (Specify) orraine stant Moodawn Funeral Hone 21. Signature of Funeral Service Licenses rederick Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) hypoxiemic Respiratory Failure /Medical Due to (or as a consequence of): Examiner Amoric Brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine The law requires that the death certificate be executed Due to (or as a consequence of): burial-t physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☑ No 9 Tunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown DM Type 2 HTN Africas Ischemic Cardiomyopathi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 ANo 2 No 1 □ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

completely filled in by the funeral director, or Attending 24 hours after deatle Funeral Director: Hospital within 2

Baltimore, Maryland 21215-0036

Box 68760.

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Records,

Vital

o to

State Registrar 29a. Certifier

(Check only

29b. Signature and title of certifier

ROOPHARINESINGH 31. Date filed (Month, Day, Year)

19Kago narmesup

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBBS 32 Adjistrar's Signature

SINAL HOSPITAL

MB BS

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

October

OF

08, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER SR. MARY KATHLEEN STEINKAMP, RSM 2009 5:30 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE VILLA BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 21,1935 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□ M 2□X Min. Months Days Hours 215-32-4140 74 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 □Yes 2√ No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 BELLONA AVE 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: WHITE If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATOR/ADMIN RELIGIOUS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERMAN AUGUST STEINKAMP CATHERINE EILEEN FOGARTY PERSONATED. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SR. MARGARET DOWNING RSM- REP 347 HOMELAND SOUTHWAY 1B BALTIMORE, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/19/09 WOODLAWN CEMETERY BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 shock, or heart failur List or one 23a. Part 1. Enter the disease, If ns that cause the not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Immediate Cause (F) Bladden disease or condition resulting in death) Due to (or as a consequence of): vas aulita Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1∐Yes 2⊡No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner or Attending Physician; The law requires that the death certificate be executed the burial-transi Division of Vital Records, P.O. Box 68760, attending physiciar as use signed by the a

page 2 should has certificate director. this funeral after death Director: the filled in by 24 hours a

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

traumatic event, the Medical Examinar must be notified

Department of Important: If it any injury or conce.

**Physician** 

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a o

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Exami

Physician/Medical

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Completed

Be

Certification: To

completely To the I within 2

Hospital

Medical 29b. Signature and title of certifier Mich - PKIO

4 Homicide

(Check only

29a. Certifier

29c. License number P3(865

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

).	Name	and	addres	ss of	person	who	complete	d cause	of death	(Item	23a)	(Type	, P
	Rn	<b>~</b>	20	6		8	21	N.		avi	tar		it

Registrar's Signature

31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 15:15 M Oct 2009 Schwar John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 24,1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1X M 2□ F 83 Minnesota 475-22-1108 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.f. any Injury or other traumatic event, Ite Market. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Directo Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 1325 Denbright Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 1944 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: White ξ 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Tucker George Melvin Schwartz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1325 Denbright Road Catonsville, Maryland 21228 Avonne <u>Gold Schwartz, Wife</u> 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Metro Crematory Inc. 10/17/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licence Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 day **Physician** disease or condition resulting in death) 1NEU WOW 11 /Medical Due to (or as a consequence of): Examiner Fibrillation Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 15 Inpatient Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Oct 16 2009

Registrar

State

31. Date filed (Month, Day,

3449 Wilkens Auz., Ste 204, Baltimone, MAD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

141)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 11:05P M MAY BLACKBURN STEWART 2009 Octobe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b, City, Town, or Location of Death 303 Woodbourne Avenue Baltimore N/A . Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Dec 17, 1947 9. Birthplace (State or Foreign Country) Maryland 1 □ M 2 🛛 F Months Hours Min 220-50-0996 Director 61 Dec Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🏹 No Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 75 N. Main Street 21904 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married ☐ Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Paint Associate Retail Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Sara Raile John Harvey Blackburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashlee Hart, Daughter 303 Woodbourne Avenue Baltimore. Maryland 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 10/15/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death MYELOID LEUKEHIA disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Due to (or as a consequence of) and Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Dav Year 1 ☐ Yes 2 2 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) RESIDENCE 힏 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral Certificate: 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No s after death. 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a

To the Funeral D Hospital 1 Kcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00057450

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

OCT 1 9 2009

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STREET

BALTIMORE MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH GREENE

32. Registra Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ruth Helen Stroup October 16, 2009 6:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Charlestown Care Center Catonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2√2 F 94 1915 Director May 9, 224-20**-**8561 Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10h County Department of Health and Mental Hygiene. Important: If Items 23a or 28a-f show any njury or other traumatic event, the Wedical Event in court by retified a gine. 1 ☐ Yes 2 No Funeral Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 719 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Burgess ပ William Hern 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7601 Stoney Creek Lane Ellicott City, MD 21043 Rennes Bowman, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 10/17/09 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service License Thomas Gregor 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Breast cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2ZNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30989 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

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den Choice Lane Catonsville MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael Robert Tucker Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day October 14, 2009 Physician/ 1345 hrs **Medical Examiner** Tucker Michael Robert c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Garrett Oakland 13147 Garrett Hwy 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Euneral** Months Days Hours Min. April 6,1964 CountryMaryland Director 45 219-92-5729 1× M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County 1 Yes 2 X No 123a or 28a-f show 1 notified at once. Middle River Baltimore Md. death with the Maryland Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 21220 17 Valleyarber Court Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 X No Yes ō Specify: White 2X No specify: Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural" If Yes, Give Year Yes Divorced is marked other than "natural", atic event, the Medical Examiner \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pest Control Exterminator Baltimore, MD 21215-0036 12 years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Sandra tment of Health and Mental I rtant: If item 27 is marked or other traumatic event, it Lester Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1726 Drexel Road, Dundalk, Md.21222 Lester Tucker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition October crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dundalk, Maryland 19, 2009 Christ Lutheran Cem. Donation 5 Other Specify: Signature of Funeral Service Licensee) 22. Name and Address of Facility injury ( Connelly Funeral Home Of Dundalk, P 7110 Sollers Point Road, Dundalk, M 23a. Part I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Physician Between Onset and Death Medical a. Contact Shotgun Wound of Chest Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial -23d. Date of delivery Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 9 Unknown by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 No 3 Probably 4 Unknown <u>م</u> Records, P. requires Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? has 2 sł The law No Yes 2 No 1 🗸 Yes certificate 1 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: 1 Residence 6 V Other: Scene examiner? Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 this 2 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month Day, Year) Oct 8, 2009 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject shot self Certification: 0000 hrs Yes 2 V No Natural Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide or Town, State) 13147 Garrett Hwy, Oakland, MD Could not be determined (Specify) In a motor vehicle Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 15, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

2. Registrar's Sign

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Warren E. Taylor, III Oct 8, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Frankford Nursing & Rehab Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Director 212-88-6890 48 Jan 3, 1961 Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Weddest Exercited must be notified a once. Director Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 1802 DeSoto Road 21230 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify Ş 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contee Sand & Gravel Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances A. Wagner Warren Taylor Jr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 DeSoto Road Baltimore, Maryland 21230 Frances Taylor Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/09 Marriottsville, Maryland 4 ☐ Donation 5 Other (Specify) Crestlawn Memorial Gardens 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23 First . Enter the dr ease, or complections that caused the death shock, or heart fillure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Dusto (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown Auer rnis certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 Ū Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manyer of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director; filled in by the 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

and manner stated.

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#14perfff, G896, 10/19/09, WS

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

8:45p

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

1 □Yes

29d. Date signed (Month, Day, Year)

Day

2 No

Year

4 Unknown

1X Yes 2 No

Maryland

N/A

U.S.A.

Black, White, etc. **Caucasian** 

Black-

M

completely

State

Medical

29a, Certifier

29b. Sig

(Check only one

Day. Registrar

ture and title of certifier

DHMH 17 Rev 1/2001

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 03:00 PM 10 NORMA MAY TRACEY 12 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A HOSPITAL TSaltimore Good Samaritan If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2√2 F 84 JUNE 27,1925 MD 214-22-7091 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10h County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modesl Examinar must be natified at once. Yes 2 No Director BALTIMORE N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21206 3907 PARKSIDE DR Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status

If Yes, Give Year or Dates:

College (1-4or 5+)

**Physician** /Medical **Examiner** 

Completed by

Be

၉

上として 2

Baltimore, Maryland 21215-0036

1 ☐ Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

ARTHUR G. BURGAN

21. Signature of Funeral Service Licensee

19a, Informant's Name/Relationship (Type, Print)

JOSEPH STEPALOVICH-NEPHEW

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rudrappa. 900d

31. Date filed (Month, Day, Year)

Examiner Be Completed by Physician/Medical attending p certificate has b Medical Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Hun /	5/	6415 BELAIR RI	BALTIMORE,	MD 21206	
23a. Part 1. Enter the disease, or conshock, or heart failure.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	INTRACER	EBRAL HAE	MORRAGE		Onset and Death
resulting in death)	Due to (or as a consequence of	f):			
Sequentially list conditions,	b	f):			-
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,			
resulting in death) Last	Due to (or as a consequence of	f):			
	d				
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	•		23d. Date of deli	very
in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part I	. 23e. Did tobacc	o use contribute to	the cause of death?
HYPERTE	NOIDN		1	2 □ No 3 □ Pro	obably 4 Unknown
[i			24a. Was an	24b. Were aut	topsy findings available
			autopsy performed′ 1 □ Yes 2	death?	2 □ No
25. Was case referred to medical examiner?			e of Death (Check only one)		
1  Yes 2 1√10	Hospital: 1 Inpatient 2 ☐ ER/Out	tpatient 3 □ DOA Other: 4 □ No	ursing Home 5 Residence	6 ☐ Other (Spec	cify)
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investiga	(Month, Day, Year) In	ime of 28c. Injury at Work?  M 1 □ Yes 2 □	28d. Describe how in	ijury occurred	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		m, street, factory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
29a. Certifier (Check only one)  Certifying 2 Medical Ex	Physician: To the best of my knowledge caminer: On the basis of examination and and manner stated.	, death occurred at the time, date a d/or investigation, in my opinion, de	nd place, and due to the causath occurred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	n, Day, Year)
3 wem	M.D	LIMPS	790/	0/12/2	009

1 □Yes 2 XNo

16a. Decedent's Usual Occupation

PO BOX 1055

HOMEMAKER

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

WHITE

Specify:

OWN HOME

18. Mother's Name (First, Middle, Maiden Surname)

CLARA KATHERINE MAY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDGEWOOD, MD 21040

Samaritan Hospital, 5601 Lown Raven Blud, Baltimore 21239

10/15/09

16b. Kind of Business/Industry

20c. Location - City or Town, State

BALTIMORE, MD

MILLER-DIPPEL FUNERAL HOME, INC

State Registrar

09-07969 Ivan Wood Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 33345

		· · · · · · · · · · · · · · · · · · ·	ficate of Death	Reg. No.					
Physician/ dical Examine	/ 1	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year  October 14, 2009	3. Time of Death 0848 hrs				
dicăi Examme		I van Wood  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea						
		Johns Hopkins Hospital Bayview Medical Center	Baltimore	Baltimore NA					
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last bi			B. Birthplace (State or Country)				
* any	-		own or Location		10d. Inside City Limits				
land -f show	ē		imore	Lin Civing of What	1 X Yes 2 No				
the Maryland a or 28a-f sh tified at once	֝֞֞֞֓֞֓֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?				
r death with th or items 23a. must be notif	era -	2617 Edison Highway  11. Marital Status  1 XNever Married 2 Married Armed Forces?  Armed Forces?	21213  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer	(Specify Yes or No- 14. Race - A	American Indian, Black,				
", or it		XNever Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer	1 Yes 2 X No specify:		African merican				
ours after a state of the samine of the sami	ธ⊢	or Dates:	6a. Decedent's Usual Occupation (Give kind of	of work done 16b. Kind of Busin					
5-0036 ed within 72 hour lygiene. other than "natuthe Medical Exan	Sere	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use r						
d within ygiene, other of the Med	ŧ-	10th Grade NA F	Fork Lift Operato	or Rock T ame (First, Middle, Maiden Surname)	enn				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than te event, the Medica	8	Wallace Wood	Paule	ette Ga	rnett				
should and Me	2 1		19b. Mailing Address (Street and Number of						
e, MD I and 2 she Health and item 27 is		20a, Method of Disposition 20b. Place	6011 Lanette Road	Date   20c. Location - Ci	ity or Town, State				
nore		1 XBunal 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	Zion Cem. 10	0-22-09 Lansdo	owne, MD				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		21. Signature of Funeral Service Licensee	22. Name and Address of Facility [	Mylie Funeral H	Home plant				
Physician	+	23a. Part I. Enter the disease, or omplications that caused the death. Do			Approximate Interval				
'Medical .aminer		failure. List only one cause oil each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	i		Between Onset and Death				
<u> </u>		Sequentially list conditions, if any, leading to immediate b							
min	ĔΙ	cause. Enter Underlying Cause (Disease or injury that initiated							
nted id ransit	ָרְאַבּן <u>'</u>	events resulting in death) Last  Due to (or as a consequence of):  d.							
760, icate be executed icate be executed the burst - transit the burst - transit //Medical Examiner	dica:	UNPENDED AMENDED							
	JINIC 2	IF FEMALE: 23b. Was decedent pregnant in the	2 Tetente non	23d. Date of de	elivery Day Year				
of Vital Records, P.O. Box 687 ling Physician: The law requires that the death certifical After this certificate has been signed by the attending funeral director, page 2 should be detached for use as the completed by Physician/	Clai	past 12 months?  4 Pregnant at time of death	2	gnancy	Day rour				
D. Boy truthe death by the att ached for Physi	Ž-	1 Yes 2 No 9 Unknown g Unknown		23e. Did tobacco use contribu	to to the cause of death?				
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by Pertification:	≦	Part II. Other significant conditions contributing to death but not result	ulting in the underlying cause given in Part I.	1 Yes 2 No 3					
Records, I The law requires ficate has been sig page 2 should be Completed	eten				ere autopsy findings available				
e law te has lige 2 st	ξ			performed? dea	or to completion of cause of eath?  Yes 2 No				
al Relate The entificat ctor, pag	عادہ	25. Was case referred to medical	26.Place of Death (Che		163				
f Vita Physicia er this ce ral direct To Bo	<u> </u>	TV Yes 2 No			Other:				
ding P.  After S. After S. funeration:	۔ ا	(Month Day Year)	28b. Time of Injury 28c. Injury at Work?  28c. Injury at Work?  28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe how injury occurred Subject shot	d				
livisior  I or Attend after death.  Director: d in by the I	<u>Cari</u>	2 Accident Investigation 28e. Place of Injury - At home.	ne, farm, street, factory, office building, etc.	28f. Location (Street and Number					
Division ospital or Attending spital or Attending shours after death.  neral Director: After filled in by the funer Certification:		3 Suicide 6 Could not be determined (Specify) Local Street		or Town, State) Rear of 3925 Elmora Avenue,					
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, cone) 2 Medical Examiner: On the basis of examination and/o	death occurred at the time, date and place,	and due to the cause(s) and manner a	es stated.				
To the Ho within 24 To the Fu completel	- Jed	2 Medical Examiner: On the basis of examination and/o and manner stated.  29b. Signature and title of certifier	29c. License number		d (Month, Day, Year)				
	-	1 1 11. V.		OCME October 15,	,				
	+	30. Name and address of person who completed cause of death (Item 23a							
		Theodore M. King, Jr., MD. Assistant Medical Exa		nore, MD 21201					
	te <sup>3</sup> ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	alas						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1103 M Marilyn Ε. Wenrich 17 October 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore Sinai Hospital

5. Social Security Number 6 of Bultimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 □XF 66 Yrs. Aug. 16, 1943 MD Director 218-40-8981 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Experies must be notified at 1 ☐ Yes 2 ☐ No Director MD Carrol1 Eldersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7114 Tulip Court USA 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be Reilly M. Rhodus Mathilda Nelefski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any injury or other tra Mr. Harry E. Wenrich, Jr. (Spouse) 7114 Tulip Court Eldersburg, MD 21784 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 10/18/2009 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee HATCHT FUNERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 Brian L. Haight 400764 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Intracranial hemorrhage days /Medical Due to (or as a consequence of) Examiner Hypertension Due to las a consequence of: Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? coronary artery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed Diabetes mellitus Type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform Encl-stage
25. Was case referred to medical examiner? renal disease 1 ☐ Yes 2 ☐ HO 1 🗆 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 October 17, 2009

6V

anilyn Wenrich

21215-0036

Maryland

Baltimore,

P.O. Box 68760.

Records,

Division of Vital

State Registrar Jason J.C.
31. Date filed (Month, Day, Year)

OCT 19 2009

Sinai Hospital of Baltimore

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MOPM **Physician** ASHINGTON 1AR T /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 105017AL 7020  $\nabla V$ If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 □ F Director 220-86-1361 Dec 20, 1963 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a liverial Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Y⊟Yes 2 No Director Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9426 Farewell Road 21045 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Samuel Robinson Gertrude Washington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Washington 9426 Farewell Road Columbia, Maryland 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/09 Catonsville, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A Futaw Place Baltimore, Md 21217 Do not enter the mo Approximate Interval Between Onset and Death 1. Enter the disease, or com lications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 700A0 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this completely filled in by the funeral Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation Natural after death. 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)-

32. Figilitrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** 3:21 PM OCTOBER 13 Annie M. Wicks 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 □ F Director 212-24-8727 Nov 12, 1926 No Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evention in ust be inclified at Director 1 Maryes 2 □ No Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2502 Eutaw Place Funeral 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □ No Completed by Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) t of Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Surname) å Bud Lee ပ္ Annie Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Wicks 2502 Eutaw Place - 401 Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If Ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 10/17/09 Elkridge, Md. Meadowridge Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 17A7 /Medical Due to (or as a consequence of): Examiner WEEKS HYPERBILIPUBINEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed MONTHS SYNDROME HEDMO RENAL sician and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical MONTHS HERATITIS IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year ☐ Pregnant at time of death 5 Other (specify) P.O. 1 ☐Yes 2 ☐ No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas performed? Yes 2 No certificate 1 □ Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 MP AT2438946 ULTOBER 13,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARK, M-D-, UNION MEMORIAL HOSPITAL, BALTIMORE, MD.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2:10 PM CLODEN NO 12005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe Age (In yrs. last birthday **Funeral** Months 1 M 2 F Director 216-86-2398 Jul 9, 1965 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 X Yes 2 No Examiner must be notified Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6 items 23a 228 Silver Court 21231 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 XNo ≥ Specify. Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home the Homemaker traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Walker Mary Walker ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Chanel Pearson 4128 Hyden Court Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/17/09 Baltimore, Md. 4 Donation 5 Other (Specify) Mt. Carmel Cemetery 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 node of dying, such as cardiac or respiratory arrest, Melse 23a. Part 1. Enter the disease shock or heart failure. L se, or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death Do not Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Examiner Due to (or as a consequence of) physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical as attending 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has page director, Be မ Certification:

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

death with the Maryland

Baltimore, Maryland 21215-0036

this After Director: A within 24 hours a

To the Funeral C

completely filled

_					*						24a. Was an autopsy performed? 1  Yes 2		topsy findings available completion of cause of 2   No
25	Was case referred to r	medical						26	Place of Dea	th (C	heck only one)		
	examiner? 1 \( \sum \) Yes 2 \( \sum \) No	[1	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home						e 5 Residence 6 Other (Specify)				
27.		Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 🗌 Yes	2 🗆 No	280	d. Describe how injury	occurred	
	3 Suicide 6 4 Homicide	Could not be determined		Place of injury - At I building, etc. (Spec		et, facto	ory, of	ffice		28f	Location (Street end City or Town, State)	l Number or Ru	ıral Route Number,
29											d due to the cause(s)		

2 di Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

all

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

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the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>□</sup>1<sup>9</sup>6,2009 **Physician** OCTOBER 5:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 286 ST. HELENA AVENUE BALTIMORE DUNDALK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 199, 1984 MARYLAND 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 213-08-0454 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 28a-f show 1 ☐ Yes 2 X No Director BALTIMORE DUNDALK 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 286 ST. HELENA AVENUE 21222 Funeral U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, r than "natural", or item 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) DISABLED N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked oth any jury or other traumatic even once. Be DOUGLAS WILSON, SR. ဂ GLORIA FITZPATRICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL WILSON/ BROTHER 405 N. WOODWARD DRIVE, ESSEX, MARYLAND 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State BAYVIEW CREMATORY 10/17/09 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND Name and Address of Facility
ILLY & ZEILER INC. FUNERAL HOME
901 EASTERN AVENUE, BALTIMORE, MD. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pheumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Retts Syndrame 24 years Sequentially list conditions, if any, he ling is immediated cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. → Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) s been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Wunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea... 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer

DHMH 17 Rev 1/2001

State Registrar EASTERN AVENUE, BALTIMORE, MD.

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Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend ta #6 of Maryla G896 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 8:30 PM Gertrude Wolf October 0 13, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1624 Ravville Road Baltimore Parkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 5, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F 93 216-32-4042 Yrs. 1916 Pennsylvania Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes XXNo Maryland **Baltimore** Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16746 Wesley Chapel Road 21111 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify. 3 √x Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archer Henri <u>Chartier</u> Emma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>William Wolf</u> 6121 Falls Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10-16-2009 Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, gnature of F eral Service L censee Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one rions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use an tribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 7 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{XIOther} \) Other (Specify) Friends 1 ☐ Yesy 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuer of Death

burial-tran and attending physician for use as the burial P.O. Box 68760 the cate has been signed by page 2 should be detach Division of Vital Records, certificate | this funeral After t the Hospital or Attending death.

**Physician** 

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

Completed by

Be ပ

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

IF FEMALE:

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its "Madeal Examinat", sist by it tifled at

Department of Health and Mental Hygiene. mportant: If item 27 Is marked other than

Physician

/Medical

Examiner

Pages 1

any injury or other

Baltimore, Maryland 21215-0036

/Medical

10a State

25. Was case referred to medical

6 ☐ Could not be

16 2009

determined

28a. Date of Injury (Month, Day, Year) 5 ☐Pending Investigation

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

30. Name and address of per son who completed cause of death (Item 23a) (Type, Print)

1, marium 31. Date filed (Month, Day, Year) 3/2. Registrar's Signature

**Board Certified Family Med** 

MD State Lic D45421

Registrar

DHMH 17 Rev 1/2001

within 24 hours after death To the Funeral Director: filled in by the 09-07460 Jean Fritz Alexis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.											
Physicia	n/	Decedent's Name (First, Middle,Las						2. [	Date of Death Month I September	Day Year	3. Time of Death 2015 hrs	
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		N/B 6500 Blk Sargent Ro			7"	Hyattsville		Dean		Prince Geo		
Funeral		Social Security Number 6. S	ex 7. Age (In	yrs. last birth	day)	If Under 1 Ye	ar If Under	r 24Hrs. 8	. Date of Birth	(MM/DD/YYYY) 9.	Birthplace (State or	
Director		217-27-0278	M 2 F	56	Yrs.	Months Da	ys Hours	Min.	06/27/		Country) Haiti	
	ŀ	Usual Residence of Decedent										
v any		10a. State 10b. County	10c	. City, Town o	r Locatio	n					10d. Inside City Limits  1 Yes 2 x No	
Maryland 28a-f show datonce.	ě	Maryland Prince (	eorge's				Hyatts	sville_	Lin	(14H - 1		
Mary r 28a- ed at	Director	10e. Street and Number				10f. Zip Code			109	10g. Citizen of What Country?		
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leath wi	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Eve Armed Forces?			s, specify Cuba				White, et		
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5-003 led withii Hygiene. other th	E .	12 Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan									ealth	
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, MD 21215-0036 and 2 should be filed within 7 lealth and Mental Hygiene. Item 27 is marked other than traumatic event, the Medica		Marie Helene Alexi	s - Spouse							Port-au-Pri		
		20a. Method of Disposition  1   Burial 2 Cremation 3	Removal from State		f Disposit ory or othe	ion (Name of c er place)	emetery,	D	ate	20c. Location - Cit	ty or Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite Imjury or other tr		4 Donation 5 Other Specify		Gate o	f Hear	ven Cemet	tery	10/10	0/2009	Silver Spi	ring, Maryland	
Salti ermit. epartr nport		21 Signature of Funeral Service Lice	nsee Mo #	070	Hine	me and Addre	di Fune	ral Hou	ne. Inc.			
	4	23a. Part I. Enter the disease, or com	plications that caused the	death Do no	1180	OO New Ha	ampshire	e Avenu	ue, Silv	er Spring,	Maryland 20904 Approximate Interval	
Physician Medical		failure. List only one cause on e	ach line.	death. Do no	t criter tir	a mode or dym	9, 30011 03 0	010100 01 10	opiratory arro	ot, otrosti, otrosti	Between Onset and Death	
caminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										- 3	
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ial al	Medical	UNPENDED	AMENDED							· · · · · ·		
8760 ificate b	Ě	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	of pregnancy 2	Fet	al death	3 Ectopic	c pregnancy	y	23d. Date of de Month	livery Day Year	
ox 687 eath certific	sician/	past 12 months?	4 Pregnant at time			er (Specify)	•					
ge ‡ g co	Phys	1 Yes 2 No 9 Unknow	9 CHKHOWH						Logo Did to	hacca una contribu	te to the cause of death?	
P.O.	by P	Part II. Other significant conditions	contributing to death bu	it not resulting	g in the ui	nderlying caus	e given in Pa	art I.			Probably 4 Unknown	
duires en sign									24a. Was a		re autopsy findings available	
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of Vital Records, ing Physician: The law require After this certificate has been si uneral director, page 2 should be	은	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b.	Time of Ir		njury at Work	28</td <td>Bd. Describe h</td> <td>now injury occurred</td> <td></td>	Bd. Describe h	now injury occurred		
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Division tal or Attendi rs after death. al Director:	fica	2 Accident Investiga 3 Suicide 6 Could no	28e Place of Injury	- At home, fa	rm, stree	t, factory, offic	e building, e	tc. 28	8f. Location (S or Town, S		or Rural Route Number, City	
Division of Vital Potter the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificompletely filled in by the funeral director.	Certification:	4 Homicide determin		Street				N/	B 6500 Blk	Sargent Road, H	lyattsville, MD	
To the Hos within 24 h To the Fun	cal	29a. Certifier 1 Certifying Physicone) Certifying Physicone	cian: To the best of my kr	nowledge, dea	ath occur	ed at the time,	date and pla	ace, and du	ue to the caus	e(s) and manner as	s stated.	
To the within To the Comple	Medical	29b. Signature and title of certifier	and manner stated.	ation and/or ii	, vesugali		ense number		uno, date		(Month, Day, Year)	
DI	~	Land the of certifier					C.M.E.			September 2		
		30. Name and address of person who	completed cause of deat	h /ltem 23a)								
			nedical Examiner		n Stree	t, Baltimore	e, MD 212	201				
St	ate	31. Date filed (Month, Day, Year)	3. Registrar's	Signature	bare	2.1						
Regist	rar	OCT 02 20	19 Ceneva	1. 19	Park.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 ROBERT WILLIAM ADAMS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S LANHAM DOCTORS HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 ☐ F 152-34-8150 SOUTH CAROLINA AUG. 15 1944 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar is ust be notified at 10a State 1X Yes 2 □ No MITCHELLVILLE Director PRINCE GEORGE'S MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20721 10311 CLEARY LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ty⊟Yes 2 No ARMY frYes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 □Yes 2 No Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7. th and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUISE WILLIAMS D.V. ADAMS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10311 CLEARY LANE MITCHELLVILLE, MARYLAND 20721 JUDETTE ADAMS/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BELTON, SOUTH CAROLINA NEW HOPE BAPT. CEME: 10-10-2009 J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause the list of the cause (Disease or injury that initiated events resulting in death) Last onsequence of) Examiner Heumoma burial-tran and Due to (or as a consequence of): P.O. Box 68760, physician pe Physician/Medical as the attending properties for use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐Yes 2 ☐ No signed t I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s been signated by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate l 2 No 1 ☐ Yes 2 ☐No 1 TYes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes → No 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27521 30. Name end press of person who completed cause of death (Item 23a) (Type, Print) 9500 ANNAPOLIS Rd AI LANHAM, MD 20706 EACH MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

OCT 0 6 2009 DHMH 17 Rev 1/2001

State

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year 1405 Doris Irene Adams 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital Garrett 0akland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🔀 F Yrs 500-12-4141 Feb 24 1924 Missouri Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Old Crellin Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 <u>□</u>Yes <u>2</u> TNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ra1ph Ε. Mullin Elsie Irene Charlesworth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugenia M. Blumenberg, Daughter 12806 Oak Hill Ave., #11, Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 10/06/2009 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) White Chapel Mem. Gardens Gladstone, MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If iten 27 is marked other ti any Injury or other traumatic event, In-once.

Physician

/Medical

**Examiner** 

10a. State

MD

11

Director

Funeral

à

Completed

Be

**Funeral** 

Director

er than "natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Be Completed by Physician/Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Kathum	David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 2153	50
23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, t only one cause on each line.	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a. 50/5/3	Onset and Death
Sequentially list conditions, if any, leading to immediate	Due to (Ir as a consequence of):	days
	ue to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last	c	
	d	
IF FEMALE:		!

dical	d						
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions of	ring cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?			
	metabolic Acidosis	(3) Acute Rand, nonffecase ( ver anzyma beated,	y, hypoglyeasa	24a. Was an autopsy performed? 1 □Yes 2 ☑N	24b. Were autopsy findings available prior to completion of cause of death?  o 1 □ Yes 2 □ No		
Be	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)			
	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
Certification: To	27. Manner of Death 1 ဩNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	Work?	28d. Describe how inju	iry occurred		
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
ž	29b. Signature and the of certifier	1 - 1	29c. License number	29d. D	ate signed (Month, Day, Year)		

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21550

2009

State Registrar

Richard A.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Porter

To the Hospital c within 24 hours at To the Funeral D completely filled in

311 N. 4th Street, Oakland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Physician/ SEPTEMBER 30, 2009 BARBARA ANN BENSON 3:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 321 VIRGINIA ROAD STEVENSVILLE QUEEN ANNE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 58 Months AUGUST 4, 212-60-1558 MARYLAND **Director** Ĩ951 Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No **MARYLAND** QUEEN ANNE'S STEVENSVILLE 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 321 VIRGINIA ROAD 21666 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 0 1 Never Married 2 Married β 1 Tyes 2 XN0 Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give Year or Dates 'natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) EXECUTIVE SECRETARY **EDUCATION** -12other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental He flee of Health and Mental Hitem 27 is marked of rother traumatic ever ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to MUELLER LOUIS WAGNER VIRGINIA VIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STACY THOMAS/DAUGHTER 102 SOUTH ACADEMY STREET, GREENSBORO, MD 21639 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER OCTOBER 1, 1 Burial 2 XCremation 3 Removal from State 2009 4 Donation 5 Other (Specify) STEVENSVILLE, MARYLAND Signature of uneral Sovice Licenses HELFENBEIN & NEWNAM SHAMROCK ROAD, CHESTER MARYLAND 21619 **FELLOWS** FUNERAL HOME, P.A., 106 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ asta disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and-trar Due to (or as a consequence of): resulting in death) Last bunial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending 1 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Pregnant at time of death Month Day Year ed by the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perfori Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) မြ 2 No 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After the funeral pieted filled in by the funeral 5 Pending Natural N work 1 Tes 2 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

To the F

complet 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOS 02. Lycu MD 2 -Ussell 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 1131 AM CHARLES FREDERICK BECK September 28, 2009 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot EDSTON Memorial 8. Date of Birth (Month, Day, Ye)
DEC. 12, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 1931 PENNSYLVANIA **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 139-24-2110 Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, Ite Medical Examinating the Institled at 1X Yes 2 No Director CENTREVILLE MD **OUEEN ANNE** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21617 134 OPERA COURT Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Expeditation 11, Marital Status Black, White, etc. I Mayes 2 □ No If Yes, Give Year or Dates: 1951–1955 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRINTING OFF SET PLATE MAKER 12 -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET HEATHER CHARLES F. BECK ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 134 OPERA COURT, CENTREVILLE, MD 21617 MARION STREKIS BECK/ WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9-29-2009 STEVENSVILLE, MD CHESAPEAKE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reunsnin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed rector, page 2 should be del <u>۾</u> 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? 2 🗆 No 1 ☐Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records,

the ٥

State

6 ☐ Could not be

determined

10

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

29b. Signature and title of centifier

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:45p M September 25, 2009 Dorothy E. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sandy Spring Brooke Grove Nursing & Rehab Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 X F October 13,1910 New York 98 Director 217-42-2516 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Exprenent hust be notified at 1 ☐ Yes 2 No Directo **Rockville** Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code II.S.A. 20853 238 14311 Parkmanor Terrace Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 🔼 No Specify: Specify If Yes, Give Year or Dates: δ 3 X Widowed 4 □ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Madic once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Edwards Irwin Dean 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14311 Parkmanor Terrace, Rockville, Maryland 20853 Frederick J. Brown - Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/05/2009 Brentwood, Maryland Fort Lincoln Crematory ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown 9 🗆 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Denknown THRITIS, CHRONI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy 1 ☐ Yes 2 ☐ No 2 1 No funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: 1 ☐ Inpatient Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2005 cem up 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun, M.D 10301 Georgia Avenue #209; Silver Spring, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signature 05 2009 OCT Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		. For	ertificate of Death	Reg	J. No.	3. Time of Death
Physic /Med	ical	Joseph Michael Baglio  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	1, 2009 4c. County of Deatl	9:40 p M
	Montgomery Hospice-Casey House		Rockville		Montgomery	
Funeral Director		5. Social Security Number 122-18-1513  G. Sex 18 M 2 F  7. Age (In yrs. last birthda 87 Yrs.	2-18-1513 1X M 2 □ F 87 Yrs. Months Days Hours Min. (Month, Day Year) Feb. 12, 1			
e Maryland 8a-f show	Director	10a. State	Rockville			10d. Inside City Limits 1 ☐ Yes 2 🖾 No
h with th	al Dire	10e. Street and Number 4611 Harlan Street	10f. Zip Code 20853	100	g. Citizen of What Co USA	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Itemical Examination in the Institute of the concession of the Institute of the In	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ▼ Yes 2 □ No If Yes, Give Year or Dates: WWII	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify Whit	e, etc.
thin 72 hc ie. ian "natui I Medical	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work v. DO NOT use retired) cor of Jurisprudence	ing	Sb. Kind of Business/ Federal G	
be filed wi ntal Hygier ed other th	Be	17. Father's Name (First, Middle, Last) Augustino F. Baglio	18. Mother's Nam	e (First, Middle, Ma bhine F. N	aiden Sumame)	Overnment
d 2 should th and Mer 7 is marke traumatic	2	19a. Informant's Name/Relationship (Type. Print)	illing Address <i>(Street and Number or Rui</i>			
permit. Pages 1 and Department of Heal Important: If item 3 any injury or other once.		20a. Method of Disposition 20b. Place of Discemetery, c	nosition (Name of	Date 20	Oc. Location - City or	
permit. Departr Imports any in		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Francis J. Collin 500 University Blv	s Funera	l Home Inc ilver Spri	ng, MD 2090
Physician /Medical Examiner	1	23a. Part 1 Enter the disease, or complications that caused the death. Do not expression to the cause of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	1 Yes 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other ( <i>specify</i> )		23d. Date of del Month	livery Day Year
he law requires that the has been signed by toge 2 should be detach	à	Part II. Other significant conditions contributing to death but not resulting in the Coronary Artery Disease, Hypertens:		7.9	acco use contribute to	the cause of death?
The law recate has bee	Completed			24a. Was an autopsy performe 1 □ Yes 2	ed? prior to death?	utopsy findings available completion of cause of
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	on: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 Ⅳ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending  28a. Date of Injury (Month, Day, Year)  Injur	tient 3 DOA Other: 4 Nursing H	th (Check only one, ome 5 \subseteq Residen 28d. Describe how	nce 6 Nother (Spe	cify) Hospice
l or Attendi after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 □ Yes 2 □ No street, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
e Hospita 24 hours e Funeral	Medical C	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, de 2	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
Within Within To the compl	Me	29b. Signature and title of certifier  To Kouchehou, md	29c. License number		d. Date signed (Mont OCT 0 ber	th, Day, Year) 2, 2009
		30. Name and address of person who completed cause of death (Item 23a) (Typ. Jocelyne Kouatchou, MD 1355 Pic	card Drive, Rockvil	lle, MD 2	0850	
S Regis	tate trar	31. Date filed (Month, Day, Year)  OCT 05 2009  22. Registrar's Signature	del			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day **Physician** Robin Brische 12:36 AM October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimare Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🕏 F Maryland Director 12/24/1964 215-02-2697 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" ~~ any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director California St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20619 45848 Nolte Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married 1 □ Yes 2x□tNo Black. Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tri County Council Coordinator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mason Carolyn Robert Vincent Briscoe ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45848 Nolte Court, California, MD 20619 Kyle L. Briscoe/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mark's UAME 10/09/2009 Valley Lee, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DAYS Multi-organ system disease or condition resulting in death) Due to (or as a conseq ence of): /Medical Examiner rulonged hypotension Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the death certificate be executed Severe pulmonary hypertension sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? Year Day 5 ☐ Other (specify) signed by the a o 1 ☐ Yes 2 No 9 Unknown ۵. The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To : After thi 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 1 Matural 28h Time of 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fi death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar SUSAN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

MD

QUIN

RES-000

4940 EASTERN AVENUE, BALTIMORE, MD 21224

October 4,2009

			For State Registrar	State of Ma	aryianic	•	rtificate of i		ментат пу	Glerie Reg. No.		
Т	Physici	an	1. Decedent's Name (First, Middle	, Last)				<u> </u>	2. Date of De	eath Day	Year	3. Time of Death
	/Medic		LILLIAN		HH	4			OCTOB	ER O	5 2009	14:52/14
	Examin	er	4a. Facility Name (If not institution,		. ()			Location of Death		4c. C	ounty of Death	
	Francis			6. Sex 7. Age		st birthday)	If Under 1 Year	If Under 24 Hrs.		rth	9. Birthola	ace (State or Foreign
	Funeral Director		210-16-8609	1 □ M 2 🖾 F	83		Months Days	Hours Min.	8. Date of Bir (Month, Da July 29	ay, Year) 9,1926	Countr	y) sylvania
	D		Usual Residence of Decedent									
	arylar show	-	10a. State 10b. County		10c. City,	Town or Lo					100	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	ecto		t. Mary's			Califo	ornia		10 011	(114)	
	a or	Funeral Director	10e. Street and Number 23141 Marb1e Wa	17			10f. Zip Code 20619			10g. Citize	on of What Countr USA	·y ?
	leath	era	11. Marital Status	12. Was Decedent E	Ever in U.S.	. 13. \		ispanic Origin? (Si	pecify Yes or No	o- 14	Race - America	n Indian,
326	be filed within 72 hours after death with the Maryland that Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Eventing mast be neithed at	by Fur	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?			Vas Decedent of H f Yes, specify Cuba I □Yes 2 <b>X</b> No	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, et pecify: Whit	c.
21215-0036	2 hou atura icel E	Completed	15. Decedent	's Education	1	16a. Deced	lent's Usual Occup	ation		16b. Kind	of Business/Indu	ıstry
215	thin 7 ie. an "n	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5-	+)	(Give life. L	kind of work done of NOT use retired		king			
	filed within 'Hygiene."	S	12	2	<u>.</u>		Accounta				Governme	ent 
gue Bue		Be	17. Father's Name (First, Middle, L	•				18. Mother's Nam				
Ĕ	3 2 5 5	은	Nicola George  19a. Informant's Name/Relationsh			10b Mailin	g Address (Street		nine Bea			
Σ	12 s thar 7 is trau		Daniel Kenneth		nd l		Marble V		fornia.	-		Joge)
ē,	s 1 and of Health item 27 other to	1.0	20a. Method of Disposition	Bollam, Hassa			sition (Name of natory or other place	<del></del>	Date		ation - City or Tow	n, State
Ê	8 <del>+</del> <del>+</del> = 5		1⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		1		emorial Par	CCEOR	er 9, 2009	Chesap	eake, Virg	;inia
	permit. Pag Departmen Important; any injury once.		21. Signature of Funeral Service L		10100		Name and Address Mattingle	•		Iomo D	Λ	
n	8 <b>3 E 8 8</b>		Karmett P	rike			P.O. Box	270 Leonar	dtown, MI	20650	·A•	
			23a. Part 1. Enter the disease, or of shock, or heart failure. List of	omplications that caused only one cause on each lin	the death. ne.	Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-a. 1901	HEM	IC	BOWE	-				Onset and Death
Į.	/Medical Examiner		resulting in death)	Due to (or as a	a conseque	ence of):	4	. 4477		100	-0110	. 4. 4.
		7	Sequentially list conditions,	b. Due to (or as a	CONSORUE	) ING	HORTI	- HIVY	EURLISM	1 KC	PHIK	DAYS
:1	uted J insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ALT	FRO	SCLE	AONTI ROTIC	CARI	SIOVA	seuli	an DE	ASE YEARS
Ď.	exec an and rial-tra	Еха	resulting in death) Last	C. Due to (or as a	a conseque	ence of):	100 /10					*
09/89	tificate be executed g physician and as the burial-transit	edical		d								
	- O M	Med	IF FEMALE:	ľ						F		
õ n	death cerl e attendin d for use a	siclan/M	23b. Was decedent pregnant in the past 12 pronths?	23c. If yes, outcome of	2 Fetal of	death 3	Ectopic pregnanc	у		23	d. Date of deliver Month	y Day Year
	he dea	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of de	ath 5□	Other (specify) _				WOTE	oay rear
J.	w requires that the de s been signed by the should be detached	Phys	Part II. Other significant condition	່ ns contributing to death bເ	ut not result	ting in the ur	derlying cause give	en in Part I.	23e. Did	tobacco use	contribute to the	cause of death?
g.	uires n sign Id be	d by		_					1 🖎	Yes 2□	No 3 ☐ Proba	ibly 4 🗆 Unknown
ecord	w req	Completed							24a. Was	an	24b. Were autop:	sy findings available
Ľ,	The law ate has page 2 s	omp							auto perfo	psy orm	prior to com death?	pletion of cause of
	an: ] rtifica tor, p	0	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes	2 No	1 □Yes 2	No
> : -	Physician: this certific ral director,	70 B	examiner? 1 ☐ Yes 2 X No	Hospital: Inpatie	nt 2 🗆 E	R/Outpatien	t 3 DOA Oth	or:			Other (Specify)	)
	ng Pl	uo:	27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day	ry 2 v, Year)	28b. Time of Injury	28c. Injur Worl	y at </td <td>28d. Describe</td> <td>how injury o</td> <td>occurred</td> <td></td>	28d. Describe	how injury o	occurred	
sion	Attending ir death. ector: After by the fune	cati	2 Accident investigation inve	ation	,			Yes 2 □No				
		Certification:	4 Homicide determine		iry - At hom c. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location ( City or To	(Street and i wn, State)	Number or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying	g Physician: To the best of Examiner: On the basis of	of my know	rledge, death	occurred at the tir	ne, date and place	, and due to the	cause(s) a	and manner as sta	ated.
:	the H hin 24 the Fi nplete	Medical	one)	and manner sta		r Grid/O1 III						
	Co 7 wit	2	29b. Signature and title of certifier	A Charle	111.		29c. Licens	e number		29d. Date	signed (Month, D	ay, Year)
	10x,		30. Name and address of person v	. sueinfer	CK UVI	22a) (Time 1	D (g)	0 33	)	UCI	IJUIL U	5,2009 E MD 21201
	6 A		GEOFFREY R	HEINIELI)	27	Zoa) (Type, I	VTH GI	REENE	57	BA	TIMORE	E MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ire						21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Day)

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Warylan		ertificate of		R	eg. No.	0 0235
	Physici	an	Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	Day Year	3. Time of Death
-	/Medic	cal	GERALDINE S. BAI					octobe		
	Examin	er	4a. Facility Name (If not institution, gl	ve street and number)			r Location of Death		4c. County of Dea	
appli			DOCTORS HOSPITAL  5. Social Security Number 6.	Sex 7. Age (In yrs.	last hirthd	LANHAM  If Under 1 Year	If Under 24 Hrs.	8 Date of Birth		thplace (State or Foreign ountry)
	Funeral Director			1□ M 2√2 F 60	Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, 3/17/19		nwood, SC
	death with the Maryland ims 23a or 28a-f show	ō	10a. State 10b. County		ty, Town or	Location				10d. Inside City Limits 1 XYes 2 □ No
Ì	the M	Director	Maryland Prince G	eorge's Dis	trict	Heights 10f. Zip Code		1	0g. Citizen of What C	
Œ.	with Sa or					2074	. 7	1	United Sta	•
5	ms 2	Funeral	6507 District He	12. Was Decedent Ever in U.	.S. 1	3. Was Decedent of H If Yes, specify Cub			14. Race - Am	erican Indian,
OFTA/OL 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "scient Exaction must be rollified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates:		if Yes, specify Cub 1 ☐ Yes 2 No		Hican, etc.)	Black, Whi	
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. De	ecedent's Usual Occup ive kind of work done e. DO NOT use retire	pation during most of work	king	16b. Kind of Business	/Industry
12 (2	within iene. • than "	gm	Elementary/Secondary (0-12)	College (1-4or 5+)			d) -	I .	DC C	
-	filed v Hygie other 1		12 17. Father's Name (First, Middle, Las	3	Seci	retary	18 Mother's Nam		DC Governm Maiden Surname)	nent
an X	d be fantal	Be C	·					•	naidon doniamo,	
Z Z	should and Mer s marke umatic	မ	John Henry Searle  19a. Informant's Name/Relationship		19b. M	ailing Address (Street	Johnnie		, City or Town, State,	Zip Code) 2 0 7 / 7
<b>外</b> らぞん、 Maryland	od 2 sulth an 27 is rtrau		Lauressa N. Ross							Heights, MD
T é	f Hez f Hez item othe		20a. Method of Disposition	20b. F		sposition (Name of crematory or other place			20c. Location - City or	
SUITE, altimore,	Page ent o nt: If ry or		1 ☑ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.	Themoval from State		ton Nation	i	/2009	Suitland,	Maruland
Σ≣	mit. F partm portal	1 2	21. Signature of Funeral Service Lice	Truc	SILLIE				al Homes, 1	
M W	permi Depar Impor any ir once.	1	Kentall	ture MOIDE					ille, Mary	
			23a. Part1. Enter the disease, or con shock, or heart failure. Ust only	pplications that caused the deat						Approximate Interval Between
	Physician	e y	Immediate Cause (Final disease or condition	He on	tic	Fail	ure			Onset and Death
	/Medical		resulting in death)	a. Dive to (or as a conseq	uence of):		ure			
	Examiner		Compostially list sanditions	Red	na	1 Fai	lure			
43.	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):	A				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	PS	12				
68760,	icate be executed physician and the burial-transit			Due to (or as a conseq	uence oi):					
87	phys phys the	Medical		d				·		
). Box (	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  10 the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	ıl death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of do Month	elivery Day Year
О.	at the d by t etach	Phy	9 Unknown		odalo o los de		one in Post I	22a Did tol	haasa uga santributa i	to the cause of death?
S,	ires the signe	þ	Part II. Other significant conditions	. O. a Oca H	4	e underlying cause giv	ren in Fait i.	1 🗆 Ye		Probably 4 T Unknown
0.0	requi	eted	- Coag	000	101	1-0.7	1 14			
ıl Rec	: The law cate has t page 2 s	Completed	- Mepat	ic ence	pr	alopair	n9	24a, Was a autops perform	n 24b. Were a prior to death?	
Vita	ician sertifi ector,	Be	25. Was case referred to medical examiner?	Hospital:		l Out		th (Check only on	ie)	
of	Physician: r this certific ral director, I	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury		tient 3 DOA Oth	4 🗆 Nursing H		ence 6 Other (Sp	ecify)
n	ling I After funer	ioi	1 Natural 5 ☐ Pending	(Month, Day, Year)	28b. Tim Injui	ry Wor	ryat rk? ]Yes 2 ∐No	28d. Describe no	ow injury occurred	
É	or Attending after death. Director: Afte in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not l 4 Homicide determined	De I 290 Pleas of thirty. At h	ome, farm, fy)		Ifes 2 INO	28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
	Hospital 24 hours a Funeral   rtely filled	Medical Co	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my kno miner: On the basis of examina	owledge, d	eath occurred at the to	ime, date and place opinion, death occu	, and due to the o	cause(s) and manner late and place, and du	as stated. ue to the cause(s)
	o the ithin 2 o the omple	Mec	29b. Signature and title of conflier	and manner stated.		29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
	S in the last		1 TAK	lulalis	-	D525			10/4/	09
01	4		30 Name and address of person who	completed cause of death (Item	n 23a) (Ty	pe, Print)	1 lanh.	200	7 20001	. ,
J.	Sta	te_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature .	LUCK KUU	E 108/11/1	", 11/3	1, 00/06	,
	Registr		31. Date filed (Month, Day, Year) OCT 0 6 2009	Ener 1. 190	un					

09-07765 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Mayk Bagheadlian 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 6, 2009 1630 hrs Medical Examiner Baghdadlian Mayk 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 1901 West Street #208 Annapolis 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director 561-95-6473 07/01/1974 Country) 35 1 XM 2 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No Maryland Anne Arundel Annapolis death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 611 Glenfield Ct. 21401 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces' 1 X Never Married Married 2 X No Yes White 3 Widowed Divorced If Yes, Give Yea 1 Yes 2 X No specify: ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 P. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E. Baltimore, MD 21215-0036 Jewelery Store 12th Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Khajadour Baghdadlian Augenie Mahseredjian Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ပ္ John Baghdadlian/ Brother 3 Silverwood Ct., #11, Annapolis, MD 21403 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St. Demetrios Cemeter 10/10/09 Annapolis, MD Other Specify Donation 5 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Furieral Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Seizure disorder Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical #1 per ME g896 10/20/09 TT X UNPENDED g physician a AMENDED 23a,27,perME, g898 12/10/09 TT 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown

Syria

Death

Year

24b. Were autopsy findings available

death?

29d. Date signed (Month, Day, Year)

October 7, 2009

1 🗸 Yes

prior to completion of cause of

The law requires that the death certificate be Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Division of Vital

After this certificate has

Completed 24a. Was an autopsy performed? ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registra

29b Signature and

title of certifie

Victor Weedn MD JD

31. Date filed (Month, Day, Year

32. Registar's Signature

most

**ORIGINAL** 

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

26

Assistant Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Registrar  1. Decedent's Name (First, Middle	le, Last)	007	tificate of D		2. Date of Dea		3. Time of Deat
sician		Janos Csok	æ			Month Octo	ober 1, 20	7e ar 109 5:30 a
edical miner	4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, or I	Location of Death	1	4c. County o	of Death
	Holy Cr	coss Hospital			lver Sprin		M	ontgomery
ral	5. Social Security Number	6. Sex 7. Age (// 1 ■ M 2 □ F	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	( Year)	Birthplace (State or For Country)
tor	578-46-6165 Usual Residence of Decedent		93 Yrs.			January 0	3, 1916	Yugoslavia
	10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Lin
ţ	Maryland Mo	ntgomery		9	Silver Spr	ing		1 ☐ Yes 2 🗷
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
a la	8508 Milfor	d Avenue			20910			U.S.A.
Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, , White, etc.
by F	1 Never Married 2 Mar	If Yes, Give		1 □Yes 2 <b>⊠</b> No	Specify:		Specify:	*****
ed b	3 ₺ Widowed 4 □ Divorced	d Year or Dates:	16a Dece	dent's Usual Occupa	ation		16b. Kind of Bus	White siness/Industry
blet	(Specify only highe	est grade completed)	(Give	kind of work done do DO NOT use retired)	uring most of work	king		,
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Beauticia	an		Se	elf Employed
Be C	17. Father's Name (First, Middle,	, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Surname	e)
To E	Is	tnar Csoke				Maria	01ajos	
To Be Completed by Funeral Director	19a. Informant's Name/Relations	ship (Type. Print)	-L	ng Address (Street a				
	Michael Csoke			Owl Creek I				
5	20a. Method of Disposition 1   ■ Burial 2 □ Cremation	3 ☐ Removal from State	cemetery, crer	sition (Name of natory or other place	e)	Date	20c. Location - C	City or Town, State
and	4 □ Donation 5 □ Other (3			hington Cem		04/2009	Adelph	i, Maryland
any injury or other once.	21. Signature of Funeral Sarvi	- New Or	170	2. Name and Addres <b>Hines-Rinal</b> d <b>11800 New H</b> a	di Funeral	Home, Inc venue, Sil	ver Spring	g, Maryland 209
	23a Part 1. Enter the disease, o	or complications that caused the	e death. Do not ent	er the mode of dying	g, such as cardia	or respiratory ar	rest,	Approximate Interval Between
ian	immediate Cause (Final disease or condition		obe Pneumon	ia				Onset and Death
cal	resulting in death)	Due to (or as a co						
ner	Sequentially list conditions.	b. Renal Fa						
ine	Sequentially list conditions, if any, leading to immediate the result of the cause (Disease or injury)	Due to (or as a co	,	_				
dical Examiner	that initiated events resulting in death) Last	c. Systemic		ory Response	<b>e</b>			
			,					
de dical	-	0.						
N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		7 = 1 = 1 = 1 = 1 = 1			23d. Date	e of delivery
hysician/M	in the pa <i>s</i> t 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2		☐ Ectopic pregnancy ☐ Other <i>(sp</i> ec <i>ify)</i>	/		Mor	nth Day Year
hys		9 🗆 Unknown						
leted by Physician/M	Part II. Other significant condit	-	not resulting in the u	nderlying cause give	en in Part I.			ibute to the cause of death
ted	Hypoxic Respi	ratory Failure				1 🗆		3 Probably 4 Unkn
Completed						24a. Was autop	isy p	Nere autopsy findings avail prior to completion of cause
tuneral offector, page z i						1 □ Yes		leath? □Yes 2□No
Be	25. Was case referred to medica examiner?	Hospital		Othe		ath (Check only o		
10 E	1 ☐ Yes 2 🗷 No 27. Manner of Death	1 A Inpatient 28a. Date of Injury	2 ER/Outpatie	III 3 LI DOA	4 LI Nursing F	dome 5 Resid	dence 6 Other	
tion	1 X Natural 5 ☐ Pendi		/ear) Injury	Work				
Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Injury	- At home, farm, st					er or Rural Route Number,
	4 Homicide	building, etc. (	(эресіту)			City or Tov	vn, State)	
9 19		ing Physician: To the best of rai Examiner: On the basis of examiner state	xamination and/or in					
lical Ce	51107		u.	29c. License	e number	T	29d. Date signed	d (Month, Day, Year)
Medical Ce	29b. Signature and title of certifi	CI						
	1 .	^			D60826		Octobe	r 1, 2009
Medical Ce	Kenan	va Cay	th (Item 23a) (Type.	Print)	D60826		Octobe	r 1, 2009
Medical Ce	30. Name and address of person	va Cay				and 20910	Octobe	r 1, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** РМ 9:00 September 28, Carlo Cardona 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠ M 2□ F Director 26, 2009 None Sept. Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location show d other than "natural", or items 23a or 28a-f show event, the Medical Eventions in ust the milling at 1 Tyes 2 X No Director Maryland | Montgomery Silver Spring death with the 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 312 Southampton Drive United States Funeral 20903 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ary or other traumatic event, the Medical Exertion 1 ∐Yes 2 k No If Yes, Give Year or Dates: 1₺ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Other White 1⊠Yes 2□No Specify: Guatemalan \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Carlos Cardona Maria Ramos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Southampton Drive; Silver Spring, MD 20903 Carlos Cardona/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If ite any injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/02/2009 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. En'r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Conseq (Final disease or condition resulting in death)

a. Severe Intraventricular Hemorrhage Approximate Interval Between Onset and Death **Physician** 1 day /Medical Due to (or as a consequence of): Examiner b. Extreme prematurity
Due to (oras a consequence of): 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier within 24 hor To the Fune completely fi (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9/28/2009 D55515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road; Silver Sping, MD 20910 Andrea Lotze 31. Date filed (Month, Day, Year) State 02

Registrar

13

AURA

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar BOW ST.

32. Registrar's Signature

106

ELKTON MO 21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ OCTOBER 4 200 gear NANNIE CURTIS 5:14 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES COUNTY 7220 WHITE TAIL PLACE LAPLATA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🏝 F Months Days Hours Min. (Month, Day, Year) 414 30 9695 93 Yrs. Director MISSISSIPPI HINE 1916 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD CHARLES COUNTY LAPLATA 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 20646 7220 WHITE TAIL PLACE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other than injury or other traumatic event, the once. D.C. PUBLIC SCHOOLS PSYCHOLOGIST <u>6years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ AARON PETERSON JOSSIE PORTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD CURTIS/ SON 7220 WHITE TAIL PL. LAPLATA, MARYLAND 20646 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State FT. LINCOLN 1 🔣 Burial \_2 □ Cremation 3 □ 10-12-2009 BRENTWOOD, MARYLAND 4 Denation 5 Other (Special 22 Name and Address of Facility JOHN T. RHINES FUNERAL HOME 3005 12th STREET N.E. WASHINGTON, DC 20017 Funeral Service Sonature art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Dualto for sels consequence of: the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death cate has been signed by the apage 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown EMI Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 2X N 1 Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director; Af
completed filled in by the fu Accident Investigation

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

30. Name and ad State OCT 0 6 2009

Medical

Suicide

4 Homicide

29a. Certifier

(Check

only one)

3 29b. Signature and title of certifier

ess of person who completed cause of death (Item 23a) (Type, Print) DR. ASHVIN PATEL

6 Could not be

determined

License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 05200

28f. Location (Street and Number or Rural Route Number

City or Town, State

50 POST OFFICE ROAD SUITE# 304 WALDORF, MD 20602

82. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriah-transit

					<del></del> -	24a. Was an autopsy performed? 1 □ Yes 2 2 No	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to examiner?	to medical			26. I	Place of Death (0	Check only one)	
1 Yes 2 No		Hospital: 1 Inpatient 2 □	ER/Outpatient 3	□ DOA Other: 4[	☐ Nursing Home	5 ☐ Residence 6	G ☐ Other (Specify)
2 Accident	Pending investigation		28b. Time of Injury	28c. Injury at Work? 1 □ Yes	2 🗆 No	d. Describe how injury	y occurred
3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fa	ctory, office	28f	f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier 1X	Certifying Phy	ysician: To the best of my kno	wledge, death occu	urred at the time, da	ate and place, an	d due to the cause(s)	and manner as stated.

and title of certifier 29b. Sig

OCT 0 8 2009

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

M.D.

D69443

October 1,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANICE M. LEUNG 31. Date filed (Month, Day, Year)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State Registrar 32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** HILDS O AM (009 04 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROSS SERING,
Il Under 24 Hrs. MA ) LVER-MONTERMER If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Director 217-12-6572 Ashland, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinat must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 MYes 2 □ No Director Maryland Prince George's Fort Washington 10e. Street and Number 10g. Citizen of What Country? 12004 Nevin Lane 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. 1 □Yes 2↓□No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Custodial Engineer</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Childs Lucy Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fannie Robinson / Daughter 12004 Nevin Lane Fort Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Childs Cemetery 10/9/2009 Spotsylvania, VA 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licenses Tarreyl Molas 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. En Ir the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medicai Due to (or as a consequence of): Examiner BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): PNEUMONIA burial-tra Due to (or as a consequence of): P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes **2**√ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 28c. Injury at Work? s after de-Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined n 24 hours after deg re Funeral Directo pletely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🛚 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

OCT 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jayanti Patel MD, 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) Registrar's Signature

29c. License number

D0052586

29d. Date signed (Month, Day, Year)

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Charles Lee Daltor	1	For State	ate o	of Maryla	ınd / E	Departme Certifica		Health and Death	Menta	al Hyg		eg. No.	20	09 3337
Physician		egistrar . Decedent's Name (First, Midd	le,Last)							2.	Date of Dea	th	Year	3. Time of Death
Medical Examine	r					on Sr.		b. City, Town, or i	eastion of		Month Septembe		09 onty of Deat	1758 hrs
7	4	Fa. Facility Name (if not institute 302 Contour Road	on, give	street and nu	mber)		4	Mount Airy	Location of	Death			derick	
Funeral	7	5. Social Security Number	6. Sex	(	7. Age (I	n yrs. last birth	nday)	If Under 1 Year			8. Date of Bi	rth (MM/DD/	Fore	irthplace (State or
Director		214-08-7575	1 X	M 2 F	38	3	Yrs.	Months Days	Hours	Min.	May 7,	1971	C	ountry) Maryland
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DIO		Jack Titus MD.	eputy Chief Med	dical Examiner	111 Pe	nn Street, Ba	Itimore, M	/ID 21201				<u> </u>
S	tate	31. Date filed (Month, Day, Yea	1 2009 32.	Registrar's Signatur		arked						
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Physicia		egistrar . Decedent's Name (First, Middle,Last)	ale of Death	Reg. 2. Date of Death		3. Time of Death
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d		Facility Name (if not institution, give street and number)     302 Contour Road	4b. City, Town, or Location of Death Mount Airy		4c. County of Death Frederick	
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re, land f Heal			of Disposition (Name of cemetery, atory or other place)	Date	20c. Location - City o	r Town, State
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of uneral Septice Licensee	22 Name and Address of Facility Stauffer Funeral 1621 Opossumtown	Homes P.	A	1 101 700
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Box ne death c the atten	hys	1 Yes 2 No 9 Unknown g Unknown	in the underlying gauge given in Part I	23e Did tot	bacco use contribute	to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial-	þ	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause giver in Parti.			obably 4 Unknown
'ds', require been si	Completed			24a. Was a autops		autopsy findings available completion of cause of
of Vital Records, ng Physician: The law requir After this certificate has been s meral director, page 2 should	dmo			perform	med? death'	
al Ro		25. Was case referred to medical	26.Place of Death (Chec	k only one)		
Vita nysicia this ce	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/			Residence 6 Ott	ner: Scene
	n:T	(Month, Day, Year)	DUND: 28c. Injury at Work?  1 Yes 2 ✓ No	Subject shot	now injury occurred t	
Sior Attend death sctor:	catic	2 Accident Investigation Sep 25, 2009 17	50 hrs farm, street, factory, office building, etc.	28f Location (S	Street and Number or	Rural Route Number, City
Division Spital or Attendin hours after death. meral Director: A	Certification:	Suicide Could not be determined (Specify) Single Family	raini, street, ractory, office building, cto.	or Town, St		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	_	29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	leath occurred at the time, date and place, a	nd due to the cause	e(s) and manner as s	tated.
To the within To the comple	Medica	one) 2 Medical Examiner: On the basis of examination and/o and manner stated.  29b. Signature and title of certifier	r investigation, in my opinion, death occurred	at the time, date a	29d. Date signed (I	
	=	0 11 1/4	O.C.M.E.		September 26,	2009
DID !		30. Name and address of person who completed cause of death (Item 23a	1)		<u> </u>	
- V		Jack Titus MD. Deputy Chief Medical Examiner	111 Penn Street, Baltimore, MD	21201		
		31. Date filed (Mon 10 Car, Year) 1 2003 32. Registrar's Signature	1. Sarked			
Regis	ucl					

09-07500 Emmaline Dalton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2009 33373

		1- For State Registrar		Certific	cate of	Death		, ,	Reg. No.	UU	2 .000
Physici		1. Decedent's Name (First, Midd	le,Last)					2. Date of De Month			3. Time of Death
ledical Exami	iner	Limiattie E. 1						Septemb	er 25, 2009		1758 hrs
		4a. Facility Name (if not institution 302 Contour Road	n, give street and number	er)	4	b. City, Town, or	Location of De	eath	4c. County		
Funeral		5. Social Security Number	6. Sex 7. A	Ago /le igo leothi	ed by all as a l	Mount Airy	If Under 24	Um lo Data ef E	Frederic		(0)-1
Director				Age (In yrs. last bi	•	If Under 1 Year Months Day		Min.	sirth (MM/DD/YYYY	Foreign	1
		216-63-0898 Usual Residence of Decedent	1 M 2 X F	7	Yrs.	<u> </u>		Feb.2	.5 <b>,</b> 2002	Cou	<sup>intry)</sup> Maryland
any		10a. State 10b. County		10c. City, Tow	n or Location	on	· · · ·				10d. Inside City Limits
thow See.	_	Maryland Fre	derick	Me	۸ ۵					ł	1 X Yes 2 No
ɗaryland 28a-f show any 1 at once.	Director	10e. Street and Number	delick	Mt.	Airy	10f. Zip Code			10g. Citizen of WI	hat Coun	try?
the M a or 2 tiffed	ä	302 Contour Roa	nd.			0.1.	771				
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once.	Fal	11. Marital Status	12. Was Decede			Decedent of His		( Specify Yes or N		- Americ	can Indian, Black,
death	Funeral	1 X Never Married 2 M	arried Armed Force	s? 2 🗓 No	If Ye	s, specify Cubar	n, Mexican, Pue	erto Rican, etc.)	White	e, etc.	
after	by F	The state of the s	orced If Yes, Give Year or Dates:		1	Yes 2 X No	specify:		Specify:	Wh	ite
hours natur	ed	15. Decedent's Education (Spe				's Usual Docupa st of working life			16b. Kind of Bu	siness/In	ndustry
36 in 72 han "	ompleted	Elementary/Secondary (0-12)	College (1-4 c	or 5+)	5	J		,			
-00 d with greene ther t	Ë	Z 17. Father's Name (First, Middle,	Last)			Student		mo /First Middle	Eleme Maiden Sumame	<u>ntar</u>	y School
21215-0036  Juld be filed within 7  Mental Hygiene.  marked other than c event, the Medica	Be C	Charles Lee Dal	•					,		,	
21. ould b I Men	70	19a. Informant's Name/Relations		19	9b. Mailing	Address (Stree	Jennir et and Number	er Ann B or Rural Route Nu	aker Fin Imber, City or Tow	cham n, State,	Zip Code)
MD d 2 sho lth and n 27 is	ri	Barbara Fincham	/ Grandmot	117							
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exum		20a. Method of Disposition		20b. Place	of Disposit	tion (Name of ce	metery,	Date	Mary 1 and 20c. Location	City or 7	Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other St		State	•	e Cemete	2277 10	/3/2000	Mt. Ai		M1 1
Baltimo permit. Page Department of Important: Injury or ott	1	21. Signature Funeral Service	Licensee	11110	22 Ns	me and Address	of Eacility				
<b>O</b> 22 4 5	a k	Dau 1	) (Nem	W	16	auffer E 21 Oposs	uneral sumtown	Home P. Pike, F	A. rederick	. MD	21702
Physician		23a. Part I. Enter the disease, of failure. List only one cause	complications that cause on each line.	ed the death. Do n	ot enter the	e mode of dying,	such as cardia	c or respiratory a	rrest, shock, or he	art	Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final disease	a. Shotgun Wour	nd to Head						0.9	Death
-		or condition resulting in death)	Due to (or as a con	sequence of):							
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):							
	Examiner	(Disease or injury that initiated	c								
cuted and transit	Exa	events resulting in death) Last	Due to (or as a con	sequence of):							
execu an and al - tra	cal	UNPENDED	d			····					
760, ficate be ex g physician the burial	//Medical	IF FEMALE:	7				7		Tool B		
787 rtifica ing pl	N/N	23b. Was decedent pregnant in the past 12 months?	e 1 Live birth	ome of pregnancy		al death 3	Ectopic pre	gnancy	23d. Date of Month	,	ay <b>Y</b> ear
Box 687 ne death certific the attending pred for use as the	sici		TO CHANGE	adding a full and b		er (Specify)					
D. B. I the de by the	Physiciar	Part II. Other significant conditi	9 Unknown					OD- Did		15	61-110
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed rector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	þ	Ture in Other Significant Conditi	contributing to dea	atii but not resulti	ig in the ur	idenying cause (	given in Part I.				he cause of death?
rds, require been sig	Completed							- 24a. Was			opsy findings available
COF law re has be	pgu							_ auto	psy r		ompletion of cause of
tal Recian: The	Ö							1 ✓ Yes		✓ Yes	2 No
ician:	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Che				
F V Phys	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of In		Outpatient Time of Inj		ry at Work?	rsing Home 5	Residence 6 how injury occurr		Scene
Division of Vital Records, rat or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pend	ing FOUND: Day	FOI	UND:	-	Yes 2 V No	Subject she		eu	
Atte er dea rector	icat	2 Accident Inves	tigation Sep 25, 200	175   175 Injury - At home, f	0 hrs arm, street			28f Location	Street and Number	er or Rur	al Route Number, City
Div ospital or hours afte uneral Div ly filled in	틸		not be	ngle Family	,	, , ,	J,	or Town,			ar reade ramber, ony
T 7 F 9		29a Certifier	ysician: To the best of		ath occurre	ed at the time, da	ate and place, a				d.
To the How within 24 h To the Fur completely	Medical		niner:On the basis of ex	amination and/or							
F > F &	Me	29b. Signature and title of certifie				29c. Licens	e number		29d. Date sign	ed (Mon	th, Day, Year)
			M. 17			0.C.I	M.E.		September	26, 20	009
DIO	Ì	30. Name and address of perso						_			
			uty Chief Medical I		11 Penr	Street, Balt	timore, MD	21201			
C+	ato	31. Date filed (Mon Day, Mar)	ODDO 32. Régistr	ar's Signature	-						

OCT 0"1 2009 | Knewa Registrar

			For State Registrar	State of	Maryland /	Department of Certificate of		ınd Mental H	ygiene Reg. No. 200	9 33374
	Physici		Decedent's Name (First, Mid  JAME		ONROE	DUCKETT	-	2. Date of I Month SEPTE	Death	3. Time of Death 4:00 A M
	/Medio		4a. Facility Name (If not institute				n, or Location of		4c. County of D	
and the			SOUTHERN MAR			CLIN		Id Hro Lo p		GEORGE 'S
	Funeral Director		5. Social Security Number 220-60-3112	6. Sex 7.	. Age (In yrs. last bi	Yrs. If Under 1 Ye Months Da		Min. (Month,	Day, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent  10a. State 10b. Count					APRIL	3 1952 WA	ASHINGTON, DC
	Maryla f sho	ŗō			10c. City, Tow					10d. Inside City Limits 1√L Yes 2 □ No
	or 28a	Director	MD PRIN	CE GEORGE'S	NEW (	CARROLLTON 10f, Zip Cod	de		10g. Citizen of What	21
	ath wit		7610 FONTAINE				784		USA	
036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show clear Exarcher must be neithed at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	es? <b>∑</b> ] No	13. Was Decedent If Yes, specify ( 1 □Yes 2X		in? (Specify Yes or I Puerto Rican, etc.)	No- 14. Race - A Black, W Specify:	
1215-003	within 72 ho iene. • than "natur he Wedical I	Completed	(Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed)  College (1-4	or 5+)	a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	one during most ( tired)	of working	16b. Kind of Busine	·
פ	filed Hyg other	Be Co	10th 17. Father's Name (First, Middle	e, Last)		CONSTRUCTIO	T	's Name (First, Midd	PRIVATE  le, Maiden Surname)	
yland	Menta Menta arked atto ev	To B	JAMES SCOTT				EVEL	YN DUCKET	Т	
, Mary	od 2 lith a 27 ts r tra		19a. Informant's Name/Relation TAWANNA AIKE						nber, City or Town, State NHILL, MARYI	
altimore,	Pages 1 ar nent of Hea int: If Item		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		ate cemete	of Disposition (Name of ery, crematory or other NY CEMETER	place)	Date 0-2-2009	20c. Location - City LANDOVER, N	
Balt	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service		IIAIdioi	1 00 11			NKINS FUNEF VER, MARYLAN	
			23a. Part 1. Enter the disease,	or complications that cau	sed the death. Do					Approximate
	Physician	83 ay	shock, or heart failure. Lis	st only one cause on eac	77	1 7	1		. 1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequence	clerali	Cer	des VD	Scales Pes	Carella Know
		<u>.</u>	resulting in death)	b	as a consequence	of):		•	schen Pes	Un Know
3	/Medical Examiner	aminer	scuentisty list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		of):		•	Scales Pes	Un Know I
, pon,	/Medical Examiner	cal Examiner	resulting in death)	b. Due to (or	as a consequence	of): Vermon of): Dogly	cema Cema	•	Scales Des	Un know I Canknow I
08/00,	Medical Examiner whysician and the burial-transit	dical	resulting in death)  Security list or differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence	of): Vermon of): Dogly		•	Scales Pes	Un Know I
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s, P.O. Box 68/60,	Medical Examiner whysician and the burial-transit	Physician/Medical	resulting in death)  Scauntilly list coulding if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No	b. Due to (or d. 23c. If yes, outcome the pregnar and the preg	as a consequence as a consequence as a consequence me of pregnancy th 2 Fetal death at at time of death	of):  Of):	ancy	•	23d. Date of Month	Un know &
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VII A HECORDS, P.O. BOX 68/60,	aw requires that the death certificate be executed  By By By By By By By By By By By By By B	o Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or c. Due to (or d. 23c. If yes, outcomediate of the control of the co	as a consequence as a consequence as a consequence me of pregnancy th 2  Fetal death on	of):  Of):  Of):  1	ancy given in Part I.	23e. Did 1 24a. Wa 24a. Wa 1 1 Yes of Death (Check only	23d. Date of Month  I tobacco use contribute  Yes 2 \( \text{No} \) 3 \( \text{Solution} \)  Is an opsy prior death opsy 2 \( \text{No} \) 1 \( \text{Y} \)  Yene)	delivery Day Year  to the cause of death? Probably 4 Henknown autopsy findings available to completion of cause of es 2 No
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Division of vital Records, P.O. Box 68/60,	ng Physician: The law requires that the death certificate be executed the result of the law requires that the death certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial-transit of the law requirements.	Medical Certification: To Be Completed by Physician/Medical	resulting in death)  Sequential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or c. Due to (or d. 23c. If yes, outco 1	as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence Betal death at time of	of):  Of):	ancy  given in Part I.  26. Place of Other: 4 \sum \text{Nurs njury at Vork?}  Yes 2 \sum \text{Not ce}  e time, date and ny opinion, death	23e. Did 1 24a. Wa aut pet 1 1 Yes of Death (Check only) sing Home 5 Re 28d. Describ 0 28f. Location City or T	23d. Date of Month  I tobacco use contribute  I'ves 2 No 3 2  Is an 24b. Were prior death 2 In No 1 Yes  2 In No 1 Yes  I tobacco use contribute  I	delivery Day Year  to the cause of death?  Probably 4 Henknown autopsy findings available to completion of cause of es 2 No  Rural Route Number, as stated. due to the cause(s)  onth, Day, Year)

Registrar DHMH 17 Rev 1/2001

			<b>1 –</b> For State Registr <i>a</i> r	State of	f Maryland		artmen rtificat			and N		giene Reg. No.		19	35	375
	Physic	ian	1. Decedent's Name (First, Midd	le, Last)							2. Date of De Month	ath Day	, ,	Year	3. Time	of Death
	/Medi			JOHN	BYRON		EVERE	TT			Septer	mber	29 2		12 1	5 A M
	Exami	ner	4a. Facility Name (If not institution	_	•		4b. City,	Town, or	Location of	of Death		4c.	County o	f Death		
107			Frederick Memo				1	deri		0411			Fred			
I	Funeral Director		5. Social Security Number 213-44-5550	6. Sex 1 <b>∑</b> M 2 □ F	7. Age (In yrs. last	Yrs.	If Under Months	Days	If Under	Min.	8. Date of Bir (Month, Da June II	y Year	946 <sub>v</sub>	9. Birthpl Count Vashi	ace (State ry) .ngto1	or Foreign
	and	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation							10	d Incide	City Limits
	h the Maryland or 28a-f show	Director	,	erick		deric										s 2 No
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Evarriner must be notflied at		10e. Street and Number 6351 Springr	idge Parkw	ay		10f. Zip	Code	21	701		10g. Cit	zen of Wh	nat Count	ry?	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
	r dea	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race			
036	urs after death with al", or items 23a or Examinatinat be	þ	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ☐ Yes	2₩ No e		1 □ Yes 2		Specify:	i, i deite	riiodri, etc.)		Specify:	, White, e	hite	
Maryland 21215-0036	ㅁ 및 40	Completed	(Specify only highe	nt's Education est grade completed)		6a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa k done d	ation uring most	t of work	ing	16b. Ki	nd of Bus	iness/Indi	ustry	
212	filed withii Hygiene. Sther than	E O	Elementary/Secondary (0-12)	College (1-	-4or 5+)		one -	o romou,	,			r	none			
pu	be filed ttal Hygi d other event,	Be	17. Father's Name (First, Middle,	,			00				(First, Middle,	Maiden		)		
ry la	2 should be f n and Mental I is marked of raumatic eve	မ	John E. I								garet Da					
, Mai			19a. Informant's Name/Relations Linda Everett -	, ,							ay, Fre					21701
ore	es 1 a of He fitem		20a. Method of Disposition	200	20b. Place	e of Dispo	sition (Nam	ne of ther place	9)		Date	20c. Lo	cation - C	ity or Tov	vn, State	
Ē	Pag tment tant: I		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		Stauf	fer	Crema	tory		10-	L <b>-</b> 2009	Fre	derio	ck, M	ary1	and
Baltimore,	permit. Pages 1 and Department of Heali Important: If item 2 any Injury or other once.		21. Signature of Funeral Service	Licensee			2. Name an			Sta	auffer :				-	
			23a. Part1. E er the dis a se, or	complications that on	used the death. F						ike, Fr		ick,	-		2170
	Dharataian		shock r heart failure. List	only one cause on ea	ich line.					cardiac	or respiratory a	rrest,		- 1	Approxima Interval Be Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a. Due to (	or as a consequence	2N1C	Sh	oci	_					_		
	Examiner				or as a consequence	dic	ITN	fav	ce tie	17 20						
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											_	
8760,	cate be executed physician and the burial-transit	<u>m</u>	resulting in death, Last	Due to (d	or as a consequent	ce of):										
387	icate physis	dic		d							***					
Box 6	The law requires that the death certificate has been signed by the attending ploage 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live b	ome of pregnancy	ath 3[	Ectopic pr						23d. Date Mont		y Day	Year
P.O.	w requires that the despect to be signed by the should be detached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unkno	ant at time of death	n 5L	Other (sp	ecify)							Juy	1001
	gned gned	by P	Part II. Other significant condition	ons contributing to dea	ath but not resulting	g in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco u	se contrib	oute to the	cause of	death?
ord	equire en siç ould b	ed	Hyperten	sion,	Diabe	tes	Mell	itu	٤.		1 🗆 \	/es 2[	□ No 3	Proba	bly 4	Unknown
3ec	e law re has be je 2 sho	Completed	Chronic Obs	tractive	Pulmon	ari	2 Di	scen	د کار		24a. Was autop	sy	pri	ior to com	sy findings pletion of	s available cause of
a	Jing Physician: The h. After this certificate h. funeral director, page		Coronary	Artery	Diseo	40	·				1 ☐ Yes	-		ath? Yes 2	2 □ No	
Ξ	sicia certi irecto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:				Othe	r' _		(Check only o					
of	y Phys er this eral dil	ا تا	27. Manner of Death	28a. Date o	patient 2 ER/	b. Time of			4 LI NUI		me 5 Resid				)	
ion	Attending F death. ctor: After y the funera	ațio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi		i, Day, Year)	Injury	м	3c. Injury Work? 1 □ Y	es 2 🗆 N				00001100			
Division of Vital Records,	or Atte after dea Directol in by th	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod   28e. Place (	of Injury - At home, g, etc. <i>(Specify)</i>	farm, str	eet, factory,	office			28f. Location (S City or Tow	Street and vn, State	d Number	or Rural	Route Nui	mber,
-	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edical Co	29a. Certifier 1 Certifyir (Check only one) Medical	ig Physician: To the l Examiner: On the ba and mann	sis of examination	dge, death and/or in	n occurred a	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the	cause(s) date and	and man place, an	ner as sta	ated. the cause	(s)
	To the within To the Somple	Mec	29b. Signature and title of certifie		o, otatodi		29c.	License	number			29d. Dat	e signed (	(Month. D	ay, Year)	
			1 Miller	11: MX						フハ					,	
			30. Name and address of person	who completed cause	of death (Item 23a	a) (Type, I	Print)	000	74.	30		~ ( ,	~ (1)	200	<i>(</i>	
			110- 110	foii, Fre	derickM	leinoi	ial H	OSpit	al 4	00W	7 th sine	ed	Frede	erick.	MD	21701
	Sta	te	31. Date filed (Month, Day, Year)	2009 32 Re	gistrar's Signature	A	arkel	,	-			,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ELIZABETH 9/28/2009  $A^M$ 5:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE"S 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2√2 F Months Days Hours Min 579-28-2562 84 2/20/1925 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Maryland | Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3901 Suitland Road # 1219 United States 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>Financial</u> Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Webster Williams Margaret un-av. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Lomax / Son 189 Del Monte Lane Morgan Hill, CA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 10/7/2009 Harmony Memorial Landover, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Lices 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SENILE DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): CONGESTIVE HEART FAILURE Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 X No 9 Unknown

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, Inc. Magnotice.

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

ð

Completed

Be

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if than "natural", or items 23a or 28a-f sho

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

Increal Director: After this certificate has been signed by the attending physician and liy filled in by the furneral director, page 2 should be detached for use as the burial-transit Physician/Medical ş Completed Be Certification: To

within 24 hours a

To the Funeral Completely filled Medical

Division of Vital Records, P.O. Box 68760.

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 ♥ No 1 □ Yes 2 ♥ No
25. Was case referred to medical examiner?	26. Place of D	eath (Check only one)
1 ☐ Yes 2 🙀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a, Certifier (Check only one)  1	hysician: To the best of my knowledge, death occurred at the time, date and pla miner: On the basis of examination and/or investigation, in my opinion, death oc	ace, and due to the cause(s) and manner as stated.  Scurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title

29c. License number 17666065 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

	1	State of Maryland / [ State of Maryland / [	Departmer Certificat	t of He	eaith and M eath	F	Reg. No.	2005	3337
Physician		1. Decedent's Name (First, Middle, Last) Althea Everett				2. Date of Dea Month Octobe	c 2	2009	3. Time of Death 5:25p M
/Medical Examine		aa. Facility Name (If not institution, give street and number) Holy Cross Hospital		Silve	Spring If Under 24 Hrs.	9 Date of Bird	Mont	gomery	place (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F 7. Age (In yrs. last bit 1 ☐ M 2 🖾 F 89	Yrs. Months		Hours Min.	8. Date of Birt (Month, Da 3/3/192	y, Year) 20	Cou	h Carolina
	Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Tow  Maryland Montgomery  Silve  10c. Street and Number  8505 Spring Road	er Sprin	ip Code 20906			USA	n of What Cou	
hours after deat tural", or items :	by ru	11. Marital Status  1 □ Never Married  1 □ Never Married  2 □ Married  3 ☑ Widowed 4 □ Divorced  15. Decedent's Education  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 Tyes	2 TNo	panic Origin? (Sp., Mexican, Puerto Specify: tion		s	Black, White Specify:	Black
iled within 72 Hygiene. Ither than "nat nt, tre Medic	Completed	(Specify only highest grade completed)  [Specify only highest grade completed]  [College (1-40r.5+)	(Give kind of w life. DO NOT Childcar	e Pro	vider 18. Mother's Nam			ivate urname)	
2 should be f and Mental I Is marked or aumatic ever	10 8	Robert Lee	9b. Mailing Addre	ss (Street a	Eu and Number or Ru uard Ct.	cie Re ural Route Numb , Laure	er, City or	Town, State, 2	Zip Code)
Pages 1 and 3 ent of Health nt: If item 27 ry or other tr		20a. Method of Disposition 20b. Place cemei	of Disposition (^Normal tery, crematory of on Normal	lame of r other place tn '1	cem 10/1	Date 0/2009	20c. Loc Bren	ation - City or	MD
permit. F Departm Importar any Injur		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complications that caused the death. D	22. Name 3401 E	and Addres	s of Facility Fo	ort Linc l., Bren	twood		Home 20722 Approximate
Physician /Medical Examiner  the privat-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  I Terminal Dem Due to (or as a consequence of the cause). The conditions of the cause of the cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cause of the	ce of): cebovasc ce of):	ular <i>i</i>	Accident	S			
ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deati	ath 3 ∐ Ectop	ic pregnand (specify)	у			23d. Date of de Month	Day Year
uires that the de	by	Part II. Other significant conditions contributing to death but not resultin	g in the underlyir	ig cause giv	en in Part I.			□ No 3□ F	to the cause of death?  Probably 4 🛣 Unkno
The law requir ate has been s page 2 should	Completed					pe 1 □ Yes	topsy rformed? s 2 No	prior to death?	autopsy findings availal completion of cause of
ician: Thi certificate rector, pag	Be (	25. Was case referred to medical examiner? Hospital: X		Oti		eath (Check onl Home 5 Re		6 □Other (So	accify)
ding Phys h. After this funeral di		27. Manner of Death 1 Matural 5 Pending (Month, Day, Year)	t/Outpatient 3☐ Bb. Time of Injury M	28c. Inju	4 🗀 Nursing	28d. Describ	e how injur	y occurred	
al or Attending s after death. Il Director: After ed in by the fune	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)				City or	lown, State	9)	Rural Route Number,
the Hospital hin 24 hours a the Funeral I mpletely filled	ledical C	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowle control of the basis of examination and manner stated.	edge, death occu n and/or investig	ation, in my		ace, and due to to courred at the tin			as stated. ue to the cause(s)   nth, Day, Year)
To the within 2 To the complex	Me	29b. Signature and title of certifier	(2a) /Type Print		se number 3150			/5/2009	
R4		Nejib Siraj, M.D. 1500 Forest G	len Roa	d, Si	Lver Spr	ing, MD	2090	04	
St Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 0 6 2009  Seneral S. Registrar's Signature  S. Registrar'	ales						

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland		rtment of H			Reg. No.	009	3337
	Physici	an	Decedent's Name (First, Middle, La						2. Date of De Month	Day	Year	3. Time of Death
100	/Medic			MONDS					10/3/			5:31 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give		)			Location of Death	1		y of Death	1
per t			7010 Farragut St.  5. Social Security Number 6.8		ge (In yrs. las	t birthdou)	Hyattsv If Under 1 Year	111e If Under 24 Hrs.	8. Date of Bi	Prince		
м	Funeral Director			1 □ M 22C F	90 (III yrs. Ias	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)		place (State or Foreign ntry) Ida, SC
	ס		Usual Residence of Decedent			_			11/10/1			
	show	=	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits 1 Yes 2 □ No
	28a-f	Director	Maryland   Prince (	George's	Hyat	tsvi1	10f. Zip Code			10g. Citizen of	What Cour	
	with with the control		7010 Farragut Str	root				784		United		
	ms 2%	Funeral	11. Marital Status	12. Was Decedent		13. \	Was Decedent of H f Yes, specify Cuba		pecify Yes or No		ce - Americ	can Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, It e Medical Examiner must be notified at		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			ryes, specity Cuba I∐Yes 2 <b>X</b> No	Specify:	o Rican, etc.)		ack, White, of the street in t	
2-0	72 ho	Completed by	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	dent's Usual Occup kind of work done o	durina most of wor	king	16b. Kind of E	Jusiness/In	dustry
121	vithin ene. than "	d l	Elementary/Secondary (0-12)	College (1-4or		_	DO NOT use retired	1)		<b>.</b> .		
d 2	filed within Hygiene. other than '		17. Father's Name (First, Middle, Last	t)		Domes	tic	18. Mother's Nan	ne (First, Middle	Priva e, Maiden Surna		
Maryland	should be fi and Mental I s marked of umatic ever	To Be	John Henry Hill	ĺ				Rosie	Lee Smi	Lth		
ary	and M smar sumat	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street		-		ı, State, Zip	Code)
	1 and 2 Health a em 27 Is		Rosie H. Lassiste	er / Daugh	ter	7010	Farragut	Street H	lyattsvi	111e, Ma	rylan	nd 20784
ore	of He		20a. Method of Disposition  13 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	ce of Dispo netery, cren	sition (Name of natory or other plac	e)	Date	20c. Location	- City or To	wn, State
Ë	Pag tment tant; l		4 ☐ Donation 5 ☐ Other (Speci	ify)			lemorial	10/9/	/2009	Landove	r, Ma	ryland
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once.		21. Signature Funeral Service Lice	X		- 1	Name and Addres	-				
	40 = 40		23a. Part 1. Enter the divisase, or com	Mmmas			338 Mar1b				lary La	Approximate
	Physician		shock, or heart fulure. List only Immediate Cause (Final	one cause on each I	line. IMER <sup>†</sup> S			.9, 04011 410 041414				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	s a conseque		EASE					YEARS
	Examiner			ATHER	OSCLER	OSIS						YEARS
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or ar	5 3 Conseque	noe of):					- 4	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	s a conseque	nco of):						
60,	icate ba executed physician and s the burial-transit	a E		Due to (or as	s a conseque	nice or).						
68760,	4 D	edical		▲ d								
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnanc		Te			23d. D	ate of deliv	ery
B.	Tha law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown			☐ Ectopic pregnanc ☐ Other (specify)	У		M	lonth	Day Year
P.0	at the de	Phys	9 Unknown						non Did	<b>*</b>	atributo to t	the sound of docth?
S,	res tha signed be det	by	Part II. Other significant conditions	contributing to death	but not resulti	ing in the ui	nderlying cause givi	en in Part I.		Yes 2 → No		the cause of death? bably 4 🗍 Unknown
Ö	w require s been się s should b	eted										
of Vital Records,	: Tha law cate has page 2 s	Completed							24a. Was auto perf	opsy ormed? 2\ \ \ No	prior to co death?	opsy findings available ompletion of cause of
tal	ician: Th certificate ector, pag	ပို	25. Was case referred to medical	T				26. Place of Dea			1 □ Yes	2X No
>	S S	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 🗆 El	R/Outpatier	nt 3 T DOA Oth			sidence 6 🗆 O	ther (Speci	ifv)
jo c	ding Phi h. After thi funeral	i.i	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	jury 2	8b. Time of		ry at		how injury occu		
Ö	endir eath. or: Af he fu	atic	2 ☐ Accident investigation	on		,,		Yes 2 □ No		7.7		
Division	I or Attendi after death. Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, €	njury - At hom etc. <i>(Specify)</i>	e, farm, str	eet, factory, office			(Street and Num wn, State)	iber or Rur	al Route Number,
	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune		29a. Certifier 1 ☑ CertifyIng P	hysician: To the bes	t of my knowl	ledge doat	h occurred at the ti	mo date and place	and due to th	e cauce(s) and r	mannar as	stated
	To the Hospital o within 24 hours af To the Funeral Di completely filled in	Medical		miner: On the basis and manner s	of examination							
	To the within 2 To the сотрые	Me	29b. Signature and title of certifier	1	201		29c. Licens			29d. Date sign	ed (Month,	Day, Year)
			> Kakel	rand	197	MD	L	12010	08	101	5/0	9
-	2		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type,	Print)			· ·		
12	//			14300 Gal	lant Fe	ox La	ne Bowie,	Marylan	d 20715			
	Sta Registr		31. Date filed (Month, Day, Year)  OCT OR 2009	82 Regist	trar's Signatur	re week						

Rakesh Arora MD
31. Date filed (Month, Day, Year)
OCT 0 6 2009 Registrar DHMH 17 Rev 1/2001

			1 - State of Marylan Registrar		artment of H		, ,	ene g. No. 2	19 3337
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month SEPTEMB	Day Ye	3. Time of Death
N. N.	/Medio		RICHARD LESTER FULFORD  4a. Facility Name (If not institution, give street and number)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Location of Death	1	4c. County of FREDI	Death
	Funeral Director		FREDERICK MEMORIAL HOSPITAL  5. Social Security Number  6. Sex 7. Age (in yrs.)  7. The properties of the properties of	last birthday) Yrs.	If Under 1 Year Months Days	DERICK  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day,	Year) 9	BITTON  Birthplace (State or Foreign Country)  New Jersey
	the Maryland 28a-f show	rector	Usual Residence of Decedent	y, Town or Lo	Airy  10f. Zip Code		10	g. Citizen of Wha	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or	a Di	13111 Penn Shop Road			771			States
036	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantive must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 Wes 2 No If Yes, Give Year or Dates: Kores		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No		pecify Yes or No- o Rican, etc.)	14. Race -	American Indian, White, etc. White
21215-0036	vithin 72 ho ene. <b>han "natu</b> l e Modical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	during most of work ()	king	6b. Kind of Busin	,
	filed w Hygie other t	ပ္ပ	12 17. Father's Name (First, Middle, Last)	St	ructural		e (First, Middle, Ma	Construc aiden Surname)	tion
Maryland	nould be d Mental narked o	To Be	Rosser Lawrence Fulford			Mary :	Margaret	Banks	
Mai	id 2 sh Ith and 27 Is n traun		19a. Informant's Name/Relationship (Type. Print)  Sylvia A. Fulford / Wife	1	ng Address (Street a Penn Sho				ate, Zip Code) and 21771
Baltimore,	Pages 1 an nent of Hea ant: If item 2 ary or other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State	Place of Dispo cemetery, cren	osition (Name of matory or other plac	e) Sept	Date 20	0c. Location - Cit	y or Town, State
Baltir	permit, P Departme Importan any injury		4 □ Donation 5 □ Other (Specify) St  21. Signature of Funeral Service Licensee	22		ss of Facility St.	auffer Fu	meral H	, Maryland omes, P.A. aryland 21771
ji	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)		ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
00,	ficate be executed was physician and physician and street burial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to for as a consequence of the	uence ofj:	opathy	1 , 15.	hour		75years
8760,	cate b	dical	d						
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>	y		23d. Date o	,
	luires that t n signed by Ild be detac	by	Part II. Other significant conditions contributing to death but not rest	ulting in the ur	nderlying cause give	en in Part I.	1.		ite to the cause of death?  ☐ Probably 4 ☑ Unknown
Records,	The law requi cate has been s page 2 should	Completed	Hyperlipolina Denal to the				24a. Was an autopsy performe	ed? prio	
Vital	sician; Th certificate irector, pag	Be C	25. Was case referred to medical examiner?	7		26. Place of Deat	1 ☐ Yes 2 th (Check only one)		Yes 2□No
of V	Physic this ceral direct	မှ	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier		T I Italiani g Ti	ome 5 🗆 Residen		(Specify)
Division (	Attending F death. ctor: After y the funer	ation:	27. Manner of Death  1	28b. Time of Injury	Work	y at ?? Yes 2 □ No	28d. Describe how	v injury occurred	
Divi	tal or Att rs after d al Direct led in by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify				City or To`wn,	State)	or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  rtifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the car rred at the time, dat	use(s) and mann te and place, and	er as stated. I due to the cause(s)
	Tot Com	Σ	29b. Signature and title of certifier	mo	29c. License	55/0 <sup>1</sup>		d. Date signed (A	Month, Day, Year)
	16	)	30. Name and address of person who completed cause of death (Item	1 23a) (Type,	Print)				

State Registrar

1502 S. Main Street
32. Hegistrar's Signature Gail Griffin, M.D.

Mt. Airy, Maryland 21771

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar Certificate of Death		Reg. No. /	1 0000	
П	Physici	ian	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year	3. Time of Death	
/Med		cal	MORTON JOSEPH FROME  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dear	Octobe	r 02 2009 4c. County of Dea		
.40	Examir	ier	Montgomery General Hospital Olney		Montgon		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min			thplace (State or Foreign	
	Director		579-54-1603   TES M 2	June 1	7, 1941 New		
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	a-fsh	ctor	Maryland Montgomery Silver Spring			1 □Yes 2 🖺 No	
	or 28	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?	
	ath w	ral	15100 Interlachen Drive, Apt #718 20906		U.S.A.		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:  13. Was Decedent of Hispanic Origin? (\$  If Yes, specify Cuban, Mexican, Puer  1 □ Yes 2 ☒ No  Specify:	Specify Yes or No to Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh.	e, etc.	
2-0	72 ho 'natur	etec	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	rkina	16b. Kind of Business.	/Industry	
121	within lene. • than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	g	Legal Sei	vices	
<b>d</b> 2	filled y		5+ Attorney  17. Father's Name (First, Middle, Last)  18. Mother's Na	me (First, Middle,	Maiden Surname)		
<u>la</u>	2 should be and Mental is marked (raumatic ev	To Be	Julius Frome Esther	Rzezak			
ary	2 shou and M is mar	_	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or R	ural Route Numb	er, City or Town, State,	Zip Code) 20906	
∑,	and 2 lealth m 27 her tr		Beth Weyman Frome/Spouse 15100 Interlachen Dri		Silver Spi	ring, MD	
Baltimore, Maryland 21215-0036	Pa Ting Pa		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  King David Mem Grdns  20c.	Date 06	20c. Location - City or Falls Churc	,	
Ball	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee Ho #100 22. Name and Address of Facility HII 11800 New Hampshire	NES-RINA	LDI FUNERAL	HOME, INC.	
	Physician physician and as the burial-fransit	al Examiner	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):	chen		Approximate Interval Between Onset and Death  MM  Via P
P.O. Box 68760,	Se di se	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)   9   Unknown		23d. Date of de Month	livery Day Year	
rds,	w requires tha s been signed should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to ∕es 2₽No 3□ P		
Division of Vital Records,	Attending Physician: The law requires that the death stream. The law requires that the death effort. After this certificate has been signed by the atterestor: After the director, page 2 should be detached for up the funeral director, page 2 should be detached for up the funeral director.	Completed	25. Was case referred to medical 26. Place of Do	1 □Yes	prior to death? 2 No 1 Yes	utopsy findings available completion of cause of	
>	ysicia is cert direct	o Be	examiner?	ath (Check only o	<i>ne)</i> dence 6 □Other <i>(Spe</i>	26.0	
<u> </u>	ter th	Liu	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		now injury occurred	icity)	
<u> </u>	endir sath. or: Af	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
5	5 #	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tow	Street and Number or Ri vn, State)	ural Route Number,	
	4 4 P e	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and of the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred at the basis of examination and occurred	e, and due to the urred at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)	
	To the To the Complet	Σ	29b. Signature and title of certifier  Med Direct  29c. License number  Dept Sm  Do504/10		29d. Date signed (Mont		
	-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ren de			
Mir.	Sta Registra		31. Date filed Wards, DO 5 2009 2. Hegistrar's Signiture	9	,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sept. 27, 2009 Year Wallace 7:00p M Ferguson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Althea Woodland Nursing Home Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) 6 / 1 1 / 1 9 2 2 9. Birthplace (State or Foreign **Funeral** Social Security Number 46 1 1 ¥M 2 □ F Days Grenada Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County r than "natural", or items 23a or 28a-f show the idedical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits MD Silver Spring Montgomery Director 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Daleview Drive 20901 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black <u>\$</u> 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 N Divorced Completed 16b. Kind of Business/Industry
Organization of 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than "retraumatic event, Inc. College (1-4or 5+) Elementary/Secondary (0-12) American States Mail Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Clarissa Ferguson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Keith Ferguson/Son 4426 Medallion Drive Silver Spring, Md20904 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important; If any injury or once. Chesapeake Crem. 10/02/2009 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Spegfy) BHYTTTP Addes RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 MO490 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Interiorcherotic Conclore, scular disease or condition resulting in death) YEAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE nse 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. TYPS 2 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed andize Gunhinging 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas page 2 autopsy Fi BLIHAKON certificate ATTIGI Division of Vital 2 🗆 No 1 □Yes 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Hospital or Attending 5 ☐ Pending investigation 1. Natural ie Funeral Director: A pletely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) To the within 2 29b. Signature and title of certifier 001852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reusbury Rd Hy attsville MB 20181 DRE, MA 4203 QL filed (Month, Day, Year) 2. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav Month Year Olive Marie Galeano September 30, 9:46 pM 2009 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 😿 F Yrs. Director 83 578-30-9492 February 15,1926 New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Mcdical Evan item must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 K No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Brantford Avenue Funeral 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, hours after Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates þ 1 ☐Yes 2K No Specify. Specify 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 should be filed w h and Mental Hygie 7 is marked other tt Telecommunication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Irving Miller 2 Mary Elizabeth Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s.
Department of Health ar
Important: If item 27 is.
any injury or other traus Jennifer M. Ferguson - Daughter 3905 Briars Road, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 10/07/2009 Silver Spring, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility ree Mo # Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 1070 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedial. Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Pulmonary Edema Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed Acute Myocardial Infarction and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) Yes 2 No o the detached 9 Unknown σ, ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ pe Rapid Atrial Fibrillation 1 ∏ Yes 2 K No 3 Probably 4 Unknown Completed Was a. autopsy performed? Pneumonia 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 certificate 1 □ Yes 2 □No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Tes 2 No Certification: To 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ; after death 2 Accident investigation 1 ☐ Yes 2 🗌 No in by the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital npletely filled 1 Exactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D63343 October 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Yuryevna Ruban, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

State Registrar 31. Date filed (Month, Day, Year)

OCT

05

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** September WALTER GREENE 302001640 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE LANHAM DOCTORS COMMUNITY HOSPITAL 8. Date of Birth
1 (Mopth, Day, Year) Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 578-58-6097 WASHINGTON, DC 63 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examinar must be notified at 1 ☐Yes 2 ☐ No Director MD PRINCE GEORGE LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 5631 DUCHAINE DRIVE U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc filed within 72 hours after Specify: BLACK 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) PRIVATE College (1-4or 5+) SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN MAGRUDER EVELYN GREENE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA GREENE/WIFE 5631 DUCHAINE DRIVE LANHAM, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: If it any injury or conce. 1 Burial 2 □ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) BRENTWOOD, MD LINCOLN CEMETERY : 10-5-2009 22. Name and Address of Facility JB JENKINS FUENRAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Innhisi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 25 No certificate 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after dearn.

To the Funeral Director: After this committely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 226 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) 6 ALMAROLIC Ricusan ecom

State Registrar

DHMH 17 Rev 1/2001

OCT 0 6 2009

Registrar's Sign

			1 - For Amend Items Registrar	State of Mar 23a, 25 per	ryland / Depa me, g89/,	rtment of b 11706/09 rtificate of	lealth and dhb Death	Mental Hyg	iene <sub>eg. No.</sub> 2009 33384
ñ	Physici	an	Decedent's Name (First, Middle, Last)	)				Date of Deat     Month	Day Year _
	/Medi		Eleanor Louise Ge				Septemb	er 28, 2009 3:40 PM	
	Examir	er	4a. Facility Name (If not institution, give	,			r Location of Dea	th	4c. County of Death
		- 1	1779 Accident-Bitt 5. Social Security Number 6. Security Number		(In yrs. last birthday)	Acciden If Under 1 Year		8. Date of Birth	9. Birthplace (State or Foreign
Ь	Funeral Director		-	M 21XF	69 Yrs.	Months Days	Hours Min		Year) 1940 Maryland
	ing makes days		Usual Residence of Decedent				J		7
	rylan thow	_	10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	e Ma Sa-f s	Sch	MD Garrett		Acciden	it			1 ☐ Yes 2 🔀 No
	or 24	Dire	10e. Street and Number			10f. Zip Code			0g. Citizen of What Country?
	s 23a	iral	1779 Accident-Bitt		· 113 T.a.	21520			USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	,	Was Decedent of F If Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	2 hou atura	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/Industry
215	thin 7 e. an "n Medi	aldı	(Specify only highest grade	completed) College (1-4or 5+)	life. I	kind of work done DO NOT use retire	during most of wo d)	orking	
	ed wit /gien er th	Son	12		Homen	aker			Own Home
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, N	,
₹	ould Men larke	은	David Alvy Thomas						h Glotfelty
Maryland	12 sh h and 7 is m rraum		19a. Informant's Name/Relationship (Ty	•					City or Town, State, Zip Code)
	s 1 and 2 of Health a item 27 is other trau		Vernon W. Georg/Hu  20a. Method of Disposition	ISDANO	20b. Place of Dispo		-Bitting		ccident, MD 21520
Baltimore,	Pages ment of h tant: If ite		1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crer Cherry Gla	natory or other place ade Cemet	ery Octo	ober 2, 20	20c. Location - City or Town, State  DO9 Accident, MD
Bail	permit Depart Import any in	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Newman P.O. Box 275, Grantsvi							
,0928	Physician /Medical Examiner bhysician and sthe pnial-transit	dical Examiner	Immediate O 6 (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):		-	rdial Inf	
Records, P.O. Box 68	The law requires that the death certificat to has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 L2No 9 □ Unknown	3c. If yes, outcome pf 1 □Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	]∈ctopic pregnancy ] Other (specify) _	/		23d. Date of delivery Month Day Year
rds, P	quires that n signed b ıld be deta	by	Part II. Other significant conditions cor	ntributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to the cause of death?
Reco		Completed						24a. Was ar autops perforn 1 Yes 2	y prior to completion of cause of
Vita	lysician; Th lis certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one	
	di Si	2	1 X Yes 2 No		2 ☐ ER/Outpatien	t 3 DOA Oth	er: 4 🗌 Nursing	Home 5X Reside	nce 6 Other (Specify)
u	fte ng	ë.	27. Manner of Death 1   ↑ Natural 5 Pending	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred
Division or	or Attending ifter death. Director: After in by the f. ner	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	- At home, farm, stre (Specify)		Yes 2 □ No	28f. Location (Str City or Town	eet and Number or Rural Route Number, State)
_	To the Hospital or Attendi within 24 hours after death. To the Fune al Director: A completely filled in by the f.	Medical Ce	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	sician: To the best of a ner: On the basis of ea and manner state	xamination and/or inv	occurred at the tirvestigation, in my	ne, date and plac pinion, death occ	e, and due to the ca surred at the time, da	suse(s) and manner as stated. ate and place, and due to the cause(s)
	To the vithin To the complex c	Me	29b. Signature and title of certifier	//		29c. Licens	e number	29	d. Date signed (Month, Day, Year)
	F>F0		1 4	7 1/16	./_	R0603	12		9/29/09
			3 Hame and address 1 person who co	mpleted call e of deat	th (Item 23a) (Type I		± 6m		1101101
		3	Linda ST Stresky,	1,1	. , , , , , .	ourth Str	eet Oak	land, MD	21550
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	a. Mal			

		State of Maryland / Dep  1 - State Registrar Ce	artment of Health and Nertificate of Death	, ,	ene . No. 2009	33385
		1. Decedent's Name (First, Middle, Last)		2. Date of Death	3	3. Time of Death
Physici		LAWRENCE FRANKLIN HUDSON		Month September	Day Year 18 2009 1	.1:45 P <sup>M</sup>
/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ocp compe	4c. County of Death	1.47 1
		Manor Care Nursing Home	Silver Spring		Montgomery	,
Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Birthplac	e (State or Foreign
Director		214-28-9496 1⊠ M 2□ F 78 Yrs.		Feb. 3, 1		gton. DC
р ,		Usual Residence of Decedent		•		
aryla shov	_	10a. State 10b. County 10c. City, Town or Le	ocation		10d.	Inside City Limits
8a-f	Sc	Maryland Montgomery Silver				1 ☐ Yes 2X No
# di	i	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country	?
death with the Maryland ms 23a or 28a-f show	Funeral Director	2013 Lansdowne Way	20901		U.S.A.	
er de	nu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1953	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc.	Indian,
s aff	by F	If Yes, Give	1 □Yes 2 No Specify:		Specify: Whit	e
5-UU36 72 hours aft natural", or		1755	edent's Usual Occupation	1.00	b Kind of Duninger (Indus)	
72 n 27 n an an an an an an an an an an an an a	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	ing	b. Kind of Business/Indus	ıry
withi ene.	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	Realtor		Real Estate	
filled Hygi		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma.	iden Surname)	
d be ental ked c	To Be	Brooke F. Hudson	Ruth Y	. Shaefe	r	
mari	ř		ing Address (Street and Number or Run			ode)
Ma nd 2 s lith au 27 is r trau	ĺ					
DESILITIONEY, MISTYIANG ZIZIS-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show withinty or other traumatic event, the Wedfeel Even, incl. out the profitted at once.			8 Piccadilly Road, osition (Name of matory or other place)	Silver S	c. Location - City or Town.	0906 , State
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altimor rmit. Pages spartment of portant: If it portant: If it	10	4 □ Donation 5 □ Other (Specify) Maryland  21. Signature of Funeral Service Licenses 10 # 2	Veterans Cem. 10/0 2. Name and Address of Facility HIN	U//U9  Cr	ownsville, N	Maryland
Dan permi Depa Impo any Ir			800 New Hampshire			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	t, Ar	oproximate terval Between
Physician	i i	Immediate Cause (Final disease or condition	RDIAL INFAR	- 1	Or	nset and Death
/Medical		resulting in death)  Due to (or as a consequence of):	TOTAL	C IIII		Julian
Examiner		Sequentially list conditions, b. OSTEDMYEZITI	2		6**	nonths
p #	Examiner	it ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ecute and trans	am					
f ou, te be ex sician a		Due to (or as a consequence of):				
o	dical	d				
	Mec	IF FEMALE:				
Attending Physician: The law requires that the death certific rideath. The control of the contro	sician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [	☐ Ectopic pregnancy		23d. Date of delivery Month Da	Voor
e de:	sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 [	Other (specify)		Month Da	y Year
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us, r.C.	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		cco use contribute to the c	
w requires to been signer should be considered.	Completed			1 ∐ Yes	2 No 3 Probabl	y 4 🔀 Unknown
e 2 sh	l ple			24a. Was an autopsy	24b. Were autopsy	findings available etion of cause of
The The page	Ñ			performer 1 ☐ Yes 2 5	d? death?	
sician: The certificate irector, page	Be (	25. Was case referred to medical examiner?	26. Place of Death			
hysia his c	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 □ DOA Other; 4🗶 Nursing Ho	me 5 Residenc	ce 6 ☐ Other (Specify)	
ding Pt	ü	27. Manner of Death 1 ★ Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how		
Vitendi death. ctor: A y the fu	atie	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream, stream building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Ro State)	oute Number,
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To the Hospital or Attendi  within 24 hours after death.  To the Funeral Director: A  Completely filled in by the fu	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occur	and due to the cau- red at the time, date	se(s) and manner as state a and place, and due to the	ed. e cause(s)
To th withir To th	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day	/, Year)
I-VA		M.S. ways	D-17874		9-25-20	09
	-	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			<u>-</u>
		S. M. NAYAR MD 3717 3615		vo, Mi	D 20722	
Sta		31. Date filed (Month, Day, Year)  OCT 05 2009  Level 1. Registrar's Signature				
Registr	ar	OCT 05 2009 Server S. Jan				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 19-2009 Albert BUNEIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Creorges

9. Birthplace (State or Foreign Country) forestville ForeStville

If Under 1 Year | If Under 24 Hrs. | 8

Months | Days | Hours | Min. | 8 Home Nurseng Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 100 M 2□ F 577-04-5990 Usual Residence of Decedent Yrs. Director Jashington De 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notifled at Prince Georges forestrille 1 Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be #203 6555 Pennsylvania Ave 2074 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 ☐ Widowed 4 M Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PrV+ 12 Retail marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f h and Mental H humphrei Lee Rowena Harris 19a. Informant's Name/Relationship (Type. Print) (Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is QUE#203 forestville 6555 Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Riverdale Crematory 10-5-09 Riverdale 22. Name and Address of Findlity A. Sanders & Sons mortuary 21. Signature of Funeral Service License VA 22079 7908-B Kincannon Ply lorton 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Encephaboath Physician disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner accident PAN relig vascu 5 cure fally list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an was a... autopsy performed? Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗷 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760 P.O. I Records, Division or Vital To the Hospital or Attending Physician:

altimore, Maryland 21215-0036

n 24 hours after death.

he Funeral Director: After th
pletely filled in by the funeral

State Registrar

Medical

and manner stated.

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

0-51520

09-24-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram

Pishdad

7420 marlboro

31. Date filed (Month, Day, Year) 02

29b. Signature and title of certif

29a. Certifier

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e Funeral Director; A pletely filled in by the fu

death.

Box 68760.

P.0.

Division of Vital Records.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 XNatural

2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

5 Pending

investigation

determined

6 ☐ Could not be



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Janelle Williams, M.D., 9901 Medical Center Drive, Rockville, MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 M certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

20854

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October Physician 2009 Naomi Barton Hoke 09:27 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 101 Louise Court North East Ceci1 | Months | Days | Hours | Min. | Min. | June 11, 1926 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 TF 212-34-5896 83 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b County 10c. City. Town or Location if than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 □Yes 2 No Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Louise Court 21901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No. Specify: White ģ Specify 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be t. Department of Health and Mental - Important: If item 27 is marked oil any injury or other transmission. Be Emerson Barton, Sr. Virgie Bostic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Cornette / Niece 101 Louise Court, North East, Maryland 21901 20b. Place of Disposition (Name of Norther Last Wethods to Cotton 8, Church Cemetery 2009 8, 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 Removal from State North East, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 . f. 11. Enter the dise shock, or heart failure. or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** unknown Due to (cr) s a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of Inju-that initiated events resulting in death) Last physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No Month Year Day 5 Other (specify) signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 **1** No 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madho Sachder E.Cec: AUC. 31. Date filed (Month, Day, Year)
OCT 0 R 2009 32. Registrar's Signatur State

Registrar DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

			1 - State Registrar	State of Marylar	•	artment of rtificate of		ind Menta	l Hygien	2 U U D	33389
			1. Decedent's Name (First, Middle, Last)					2. Date Mor	of Death	ay Year	3. Time of Death
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	Examin		4a. Fecility Name (If not institution, give s			4b. City, Town	or Location of	f Death	4	c. County of Dea	h
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	Funeral		Social Security Number     6. Sex	7. Age (In yrs.	• •	If Under 1 Yea Months Day		Min. 8. Date	of Birth oth, Day, Yea	9. Bir Co	hptace (State or Foreign buntry)
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and	¥		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity. Town or Lo	ocation					10d. Inside City Limits
Aaryt	28a-f ehow	٥									1 X Yes 2 □ No
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leeth	iteme 23a ner must	Funerai	7U Research Road	2. Was Decedent Ever in U	J.S. 13.	Was Decedent of		in? (Specify Ye		14. Race - Ame	erican Indian,
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2 st	Department of Health and Mental Hygiene. Important: if Item 27 is marked other then eny injury or other traumatic event, Item Magnes.		19a. Informant's Name/Relationship (Ty)  Catherine L. Hulbe							or Town, State, . 20770	ZIP Code)
1 and	Healt em 2 ther		20a. Method of Disposition			osition (Name of		Date		Location - City or	Town, State
Pages	10 to 10 to		1 😡 Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, cre	matory or other p		10/6/200		entwood,	
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/1	ysician Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deale cause on each line.  CM DULL  Due to (or as a conse	sema	ter the mode of d	ying, such as o	cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
н	hysician and the burial-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a))).							
Attending Physicien: The law requires that the death certificate be executed	by the attanding phatached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnar □ Other (specify)				23d. Date of de Month	livery Day Year
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و ا	5 70		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				scribe how in		
di	ath. rr: After ne funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day rear)	injury		☐Yes 2☐N	No			
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Tott	withi To the	X	29b. Signature and title of christier	in, MD			25001			Date signed (Mon 0 - 0 2 - 00	
	5		30. Name and address of person who co	mpleted cause of death (Ite		Print)	DR. L	INTHO	UM I	MO 2109	0
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign				.,,			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician OCTOBER** 2009 MARY HUGHES 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE BALTIMORE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, JULY 12 9. Birthplace (State or Foreign Country)
WASHINGTON, DC **Funeral** 1 □ M 2 🖾 F Director 577-32-1451 84 1925 Usual Residence of Decedent within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ed other than "natural", or items 23a or 28a-f shor event, the Medical Examinat must be modified at MD PRINCE GEORGE'S Director CAPITOL HEIGHTS 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LEROY GORHAM DRIVE 5003 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 10 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No BLACK þ Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th ADMINISTRATIVE ASSISTANT GOVERNMENT Health and Mental Hygien 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be MARY L. SAMUEL W. HALL WASHINGTON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other tran-9160 CHERRY LANE LAUREL, MARYLAND 20708 LISA BROWN CROSS/DGT 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE MARYLAND RIVERDALE CREMATORY 10-6-2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final with unknown **Physician** Metastatic cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery for u Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Dav Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **...** №0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Mann of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending I hours after death uneral Director: 2 Accident investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) the within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 7 DKy apalise M.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZOO, Reisterstown, MD. 21136 25 Main St., Suite Kaya pakse, M.D

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

OCT 0 6 2009

Division of Vital Records, P.O. Box 68760.

32. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ctuber Emma R. Hartman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, May 12, . Age (In yrs. last birthday, **Funeral** Days Hours Min Months 208-22-9461 Yrs 1926 83 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "Accidal Experience", and the notified at Director 1 ☐ Yes 2 🔀 No Meyersdale PA Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 15552 1795 Deal Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MNO If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XX No Specify. ģ Specify: 3 ₩ Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental em 27 Is marked o Olga Grenke Edward Hartge ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 124 Philson Rd., Meyersdale, PA 15552 ant of Headants if Item 27 William Hartman/Nephew altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or 4 Donation 5 Dother (Specify) Mt. Lebanon Cemetery Oct. 8, 2009 Glencoe, PA 21. Signature of Funeral Service Lic 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina **Physician** cardio vasular dea disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Certification: To Be Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) 1 Natural 5 Pending death. neral Director: A 2 🗆 No investigation 1 ☐ Yes 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00066101 . Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul Hanan cheema Seten 900 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 02, 2009 **Physician** 4:30 M George William Hartman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 40 Main Street, Apt. 205 Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. Maryland 212-44-2421 Director 62 March 22, 1947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County ral", or items 23a or 28a-f show Examiner mest be rediffed at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Lonaconing Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21539 40 Main Street, Apt. 205 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed The Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Painter Homes 7 is marked othe traumatic event. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be William Hartman Louise Greenfelter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaqueline Hartman - Wife 40 Main Street, Apt. 205, Lonaconing, Maryland, 21539 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 04. Department of h Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **Cumberland Crematory** Cumberland, Maryland 2009 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** ENSTAGE Tone VEAR /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending after death.

Director: Af
I in by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only 2 29b. Signature and title of 29c. License number 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 928 BIShoo 31. Date filed (Month, Day, 32. Registrar's Signature Your) State - 6 ZUU3 Registrar

ARION JACKSON Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day Year September 30, 2009 Medical Examine 0429 hrs MARC AARON JACKSON
4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lotts Ford Vista Rd and Forbes Blvd Prince George's Lanham 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Director Days Hours 1X M 2 8-3-1976 Country) 212-15-9857 33 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show , or items 23a or 28a-f shor r must be notified at once. PRINCE GEORGE'S BOWIE hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10207 BALD HILL ROAD 20721 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Yes 2 X No Widowed 4 Divorced Yes, Give Yea Specify: BLACK 1 Yes 2 X No specify: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 DOMINO'S PIZZA 1 YEAR MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JANET HIGGINBOTHAM JAMES S. JACKSON Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10207 BALD HILL ROAD BOWIE, MD 20721 CHRISTOPHER M. JACKSON-BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 HARMONY MEMO. PARK 10-8-2009 LANDOVER, MD Other Specify Donation 5 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 21. Signature of Funeral Service Licensee 524 - 8TH STREET, N. E. WASH., DC 20002-5236 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Part I. Enter the disease, or complications Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a. Head, Neck, and Chest Injuries Death Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician the burial -UNPENDED AMENDED The law requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Fetal death Month Day Year 2 Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 ✓ Yes 2 No 25. Was case referred to medical the Hospital or Attending Physician: 26.Place of Death (Check only one) Division of Vital Be Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes No After 28a. Date of Injury (Month, Day Year) Sep 30, 2009 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Driver auto fixed object collision Natural 0422 hrs within 24 hours after death.

To the Funeral Director: completely filled in by the fi Pending 1 Yes 2 ✔ No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) S/B Lottsford Vista Road @ Forbes Blvd., Lanham, Md. (Specify) Major Road / Highway Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 30, 2009

er -

State Registrar 32. Registra's Signature

Assistant Medical Examiner

Victor Weedn MD JD

6 2009

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, La 3. Time of Death Month 200 **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Garrett Garrett County Memorial Hospital 0ak1and 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2X F Yrs. April 10 1939 West Virginia **Director** 70 214-42-2499 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show Director 1 Yes 2 □ No MD Garrett Mtn. Lake Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21550 United States 1405 Wheeling Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 10 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Charles Baker Anna Dawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. 1405 Wheeling Avenue, Mtn. Lake Park, MD 21550 Edna Kent, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Zion Cemetery 10/07/2009 Mt. Zion, MD 22. Name and Address of Facility
David A. Burdock Funeral Home,
21 N. Second St., Oakland, MD 21. Signature of Funeral Service Licensee Ratherine Sweiter 23a. Part 1. Enter the disease, or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on one of line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 

Ectopic pregnancy 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 1 ☐ Yes 2 / NO 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 THO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation hours after death.
uneral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed ca of death (Item 23a) (Type, Print) Sotiere Savopoulos, N. Fourth Street, Suite 100, Oakland, 255 ΜĎ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

P.O.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day
September 28, **Physician** Frances D. Leith 10:00PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1397 Rollinghouse Drive Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F 73 Director March 30,1936 Virginia 579-46-9346 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Modical Expression must be redified at Maryland
10e. Street and N Frederick Frederick 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1397 Rollinghouse Road 21703 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2▼ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Binder Printing Industry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Jesse Tv1er Sarah Painter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin D. Leith/Husband 1397 Rollinghouse Road, Frederick, MD 21703 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date t⊟Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park Lawn Cemetery 10/2/2009 Rockville, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signatura of Funeral Service Licer 1621 Opossumtown Pike, Frederick,MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPOXIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Exami ZATROM MASS LUNG and Due to (or as a consequence of): Box 68760. aftending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the 1 □ Yes 2 □ No. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, **∂** disease icate has been sig ; page 2 should b Parkinsone 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia unctoid Arthrits 24a. Was an autopsy performed? 1 □ Yes 2 No certificate | Hyper lipidemic 25. Was cas referred to medical examiner? 1 yes 2 No Hospi 1 ☐Yes 2 ☐ No Hypertension Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home TResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation death. 124 hours after death.

In Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2. To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A Hussai 046361 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE PREDERICK MD 21702 195 NMZ. A. HUSSAIN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Varker OCT 0 1 Registrar

		,	1 - For State Registrar	State of Ma	ryland		rtment of F tificate of		nd Men		ene g. No.		33395
20 "	Physicia	an	1. Decedent's Name (First, Middle, L							Date of Death Month	Day	Year	3. Time of Death
	/Medic		MARY LEE LEUN					tober					
	Examin	er	4a. Facility Name (If not institution, g  Rockville Nursi	4b. City, Town, o		Death			ity of Death itgome:	<b>~</b> V			
	Funeral	-	5. Social Security Number 6.	t birthday)	If Under 1 Year	If Under 24	1 Hrs. 8. [	Date of Birth Month, Day,	I		place (State or Foreign		
	Director		579-38-7158	1□ M 2 <b>Ö</b> F	87	Yrs.	Months Days	Hours	Min. Oc	t.22,	1921		ington, DC
and	<b>&gt;</b>		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Γown or Lo	cation					1	10d. Inside City Limits
Maryl	f sho	tor	Maryland Montgon	nerv	Si1	ver S	Spring						1 ∐Yes 2 X No
h the	r 28a	Directo	10e. Street and Number				10f. Zip Code			10	g. Citizen o	of What Cour	ntry?
th wit	23a o ust be	ralD	9615 Evergreen	Street			20901				U.S.		
should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1  □ Never Married 2  □ Married 3	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1	Vas Decedent of H f Yes, specify Cub I □ Yes 2⊠ No		n? (Specify Puerto Rica	Yes or No- n, etc.)	В	ace - Americ lack, White, cify: <b>Asi</b>	etc.
72 hc	'natul dical	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retire	ation during most o	of working		6b. Kind of	Business/In	dustry
within	than the Me	duc	Elementary/Secondary (0-12)	College (1-4or 5-	+)		intrepren				Chine	se Res	stuarant
filed	Hygi other ent, t	Be Co	17. Father's Name (First, Middle, La	st)					s Name <i>(Fir</i>	st, Middle, N			, cuarant
old be	Venta	To B	Pang Lee					Ngow	Shi	n Hom	1		
2 sho	and t		19a. Informant's Name/Relationship				g Address (Street						•
t and	health		Keith L. Leung/S	on	20h Płac							Diego n - City or To	, CA 92121
Pages	nt of h		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3				sition (Name of natory or other pla eaven Ce		ctober	: 07			
nit. P	artme ortani injury e.		4 □ Donation 5 □ Other (Specal 21. Signature of Funeral Service Light		100			1	2009 Hines-				ng,Maryland Home,Inc.
ber 1	B a m B		Nancy A.	Kersen	it								g,MD 20904
	ysician Medical		23a. Part1. Enter the disease, or co shock, or heart fature. List on Immediate Cause (Final disease or condition resulting in death)		nsive	Hear	er the mode of dyi		ardiac or res	spiratory arre	st,		Approximate Interval Between Onset and Death
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xecute	and Il-trans	Examiner	that initiated events resulting in death) Last	c. Seizure									
ficate be executed	sician e buria	SalE		Dement	ia								
tificat	ig phy as the	ledical											
To the Hospital or Attending Physician: The law requires that the death certification	signed by the attending physician and be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☎No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal d	eath 3	Ectopic pregnanc Other <i>(sp</i> ec <i>ify)</i> _	у				Date of deliv Month	ery Day Year
s that	gned b	by Pł	Part II. Other significant conditions	contributing to death bu	ıt not resulti	ing in the ur	nderlying cause giv	/en in Part I.		23e. Did tob	acco use co	ontribute to t	the cause of death?
equire	been sig should b									1 □ Ye	s 2□No	3 □ Pro	bably 4 ⊠Unknown
The law r	n. After this certificate has be funeral director, page 2 sh	Completed							_	24a. Was ar autops perform 1 Yes 2	y ned?		opsy findings available ompletion of cause of 2 ☐ No
siclar	rector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatier	nt 2 🗆 E	R/Outpatier	t 3 DOA Oth	or:		neck only on		Other (Cons.)	
P Py	er this eral d	n: To	27. Manner of Death	28a. Date of Injur	y 2	8b. Time of				5 Reside		-	<u>.y)                                     </u>
ndin	ath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat		rear)	Injury		Yes 2 No	0				
ital or Atte	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At hom c. (Specify)	e, farm, str	eet, factory, office		28f.	Location (St. City or Town	reet and Nu , State)	mber or Rur	al Route Number,
the Hosp	nin 24 hou <b>the Fune</b> l npletely fil	ledical	(Check only 2 Medical Ex	Physician: To the best of taminer: On the basis of and manner sta	examinatio		vestigation, in my	opinion, death		at the time, d	ate and plac	e, and due	to the cause(s)
은	vitl con	M	29b. Signature and title of certifier	us V. 50	SAME	1	29c. Licens				_	ned (Month,	
15			30. Name and address of person wh		$\overline{}$	<u> </u>	D004	/330		0	ctobei	3, 2	UU9
			Thomas V. Josep		Edmo	nston		Suite #	#207,	Rockv	ille,	MD 20	852
W. Carlot	Sta Registr		OCT 05 2		J.	fa	Med.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day Year Calvert October 0 7, Joseph Long 2009 11:45 a.M. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Mary's <u>16862 Long Road</u> Dameron If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Months Days 1**X** M 2□ F 219-07-1967 92 08/21/1917 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Maryland St. Mary's Dameron 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16862 Long Road 20628 United States

1 ☐ Yes 2 🛣 No

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

14. Race - American Indian,

White

Black. White, etc.

Specify:

within 72 hours after death with the Marylanc permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be coulded at once. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

Director

Funeral

ð

11. Marital Status

1 ☐ Never Married 2 X Married

3 Widowed 4 Divorced

**Funeral** 

**Director** 

Physician /Medical **Examiner** 

attending physician and for use as the burial-trar

P.O.

Records,

Vital

Division of

Josep

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate he completely filled in by the funeral director, page

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lete	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Owner/Operator	Liquor Store
e	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Surname)
으	Calvert Francis Long	Mary Alber	rta Trossbach
1	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rural R	Route Number, City or Town, State, Zip Code)
	Edna M. Long/Wife	P.O. Box 36, Dameron, MD	20628
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Disposition (Name of Date cemetery, crematory or other place)	e 20c. Location - City or Town, State
		. Michael's Cem. 10/10/2	2009 Ridge, Maryland
	21. Signature of Funeral Service Joenses	22. Name and Address of Facility Brins	sfield Funeral Home, P.A.
		0052 22955 Hollywood Road	, Leonardtown, MD 20650
	23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause in each line.	h. Do not enter the mode of dying, such as cardiac or re	interval Between
	Immediate Cause (Final disease or condition	a Carcinoma (Ur	man bladdy Inth
	resulting in death)  a.  Die to (or as a consection)	uence of):	
<u>.</u>	Sequentially list conditions, b.	7	
nìne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	derice of).	
xan	that initiated events resulting in death) Last C. Due to (or as a consequence of the cons	ruence of):	
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adic	d		
N/M	IF FEMALE: 23c. If yes, outcome of pregnant		23d. Date of delivery
icia	in the past 12 months?	al death 3 ☐ Ectopic pregnancy death 5 ☐ Other (specify)	Month Day Year
hys	9 ☐ Unknown		
y P	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Be Completed by Physician/Medical Examiner	_ carcinomo Prostat	& Hygertimon	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
plet		/ 0/	24a. Was an 24b. Were autopsy findings available
E O			autopsy performed? death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No
e C	25. Was case referred to medical	26. Place of Death (C	A
	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 □Other (Specify)
ical Certification: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury 28c. lnjury at Work? 28d	d. Describe how injury occurred
cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
ŧ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Speci.	ome, farm, street, factory, office 28f.	i. Location (Street and Number or Rural Route Number, City or Town, State)
ပ္ပ			
ical	(Check only 2 Medical Examiner: On the basis of examina	owledge, death occurred at the time, date and place, and ation and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	255. Signature and this of softman	119917	10/8/09
			10/0/0/
	30. Name and address of person who completed cause of death (Iter		own, MD 20650
е	James C./ Boyd, M.D. 41680 Mis 31. Date filed (Month, Day, Year) 32/Registrar's Signa	ss Bessie Drive, Leonardto	JWII, FID 20030
ar	OCT 0 9 2009 /2	A backer	

State Registra

09-07716 Please Type of Print in Black Indelials Inko Ensure Alk Copies Are Legible. State of Maryland 7 Department of Health and Mental Hygiene Curtis Leymeister 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Month Day October 5, 2009 Curtis Andrew Leymeister 0812 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Clarks Landing and Scotch Neck Road Hollywood St. Mary's **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. Director 577-92-9341 Months Davs Hours oreian 1 X M 2 47 Yrs 02/10/1962 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f shov Maryland St. Mary's 'natural", or items 23a or 28a-f sho Examiner must be notified at once, Hollywood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24576 Cotswold Drive 20636 USA Pages 1 and 2 should be filed within 72 hours after death with Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes Widowed 4 X Divorced "natural" If Yes, Give Year 1 Yes 2 X No specify: \$ Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry Elementary/Secondary (0-12) during most of working life. DO NOT use retired) the Medical College (1-4 or 5+) than, 21215-0036 Print Supervisor of Health and Mental Hygiene item 27 is marked other traumatic event, the Me 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Harry Albert Leymeister Phyllis Ann Wathen 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD Curtis Andrew Leymeister / Son 901 Augustus Drive, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date or other 1 X Burial 2 Cremation 3 Removal from State crematory or other place) October 8, Important: Department Charles Memorial Gardens Other Specify. Donation 5 2009 permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 270, Leonardtown, 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED burial **AMENDED** tending physuse as the b IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Fetal death 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown of Vital Records, P.O. icate has been signed by page 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ Completed 24a. Was an certificate has autopsy performed? death? ✔ Yes 2 1 Yes 25. Was case referred to medica funeral director Be 26. Place of Death (Check only one) examiner Hospital: 1 After this Other; ٩ 1 V Yes Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Oct 5, 2009 Natural 0758 hrs Subject bicyclist struck by vehicle the 1 Pending Yes 2 V No 2 Accident Investigation

Country) MD 10d. Inside City Limits Yes 2 X No 14. Race - American Indian, Black, P.G. County Government 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Leonardtown, Maryland Mattingley-Gardiner Funeral Home, P.A. MD 20650 Approximate Interval Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 🗸 Unknown 24b. Were autopsy findings available prior to completion of cause of 2 No To the Hospital or Attending Physician: within 24 hours after death. Certification: Division Director: filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town. determined State) (Specify) Roadway Homicide Clarks Landing and Scotch Neck Road, Hollywood, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. October 6, 2009 Name and address of person use of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Asset) State gistrar's Signature 2**009**9 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Norma L. Manheim 11:00P M September 30,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Rockville Nursing Home 8. Date of Birth (Month, Day, Year) 03/13/1924 5. Social Security Number 7. Age (In yrs. last birthday) 85 vrs If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months I Days Hours Min 295-14-6364 Ohio Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f sho event, it s. Modleal Exer drust must be notified at Director 1 Yes 2 □ No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8506 Beech Tree Ct. 20817 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces 1 ☐ Yes 2 ⅓ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Social Worker/Office Manager Private permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sydney Blaugrund Edythe Beyer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jarol Manheim / son 8506 Beech Tree Court Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 10/7/2009 4 ☐ Donation 5 ☐ Other (Specify) Ouantico Nat. Cem. Quantico, VA 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Edward Sagel M00910 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) 9-15-2009 Aspiration Pneumonia **Physician** /Medical Due to (or as a consequence of) Examiner Dysphagia 12 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cerebrovascular Accident 12 Months Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Tyes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed? 1 □Yes 2 XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1x Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Shama R. Mittal,

05 2009

31. Date filed (Month, Day, Year)

OCT

D0061382

14816 Physician Lane #152 Rockville, Maryland 20850

October 2, 2009

. Decedent's Name (First, Middle, Las		Ce	artment of H ertificate of L		Re	g. No.	- N	3340
. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month		Year	3. Time of Death
Laura Ann	Mydock				October	5, 20	09	2:20 p.:
a. Facilify Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
St. Mary's Nursin	g Center		Leonardt			St. M	ary's	
Social Security Number 6. S	DM alte	n yrs. last birthday, Yrs.	If Under 1 Year   Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Count	
219-98-8202   Sual Residence of Decedent	4:	3			05/12/1	900	New .	Jersey
0a. State 10b. County	10	c. City, Town or Lo	ocation				10	d. Inside City Lim
Maryland St. Ma	rute	Great 1	M:11c					1 □ Yes 2 🔀
De. Street and Number	Ly S	Great	10f. Zip Code		10	g. Citizen of V	What Count	ry?
22519 Iverson Dr	ive #8			0634		_	JSA	,
1. Marital Status	12. Was Decedent Ever	in U.S. 13.			ecify Yes or No-		e - America	ın Indian.
1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 No		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		ck, White, et	
3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 □Yes 21∑No	Specify:		Specify	Wh:	ite
15. Decedent's Ed	lucation	16a. Dece	edent's Usual Occupa	ation	. 1	l 6b. Kind of Bu		
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring most of work )	ing			
12	College (1-40r 5+)		Homemaker	2		Own I	Home	
7. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	aiden Surnam	ne)	
Thomas Laxsu	S			Jean	Hyneman			
9a. Informant's Name/Relationship (7	Type. Print)	19b. Maili	ing Address (Street a	and Number or Run	al Route Number.	City or Town,	State, Zip (	Code)
Jean Laxsus/Moth	or	450	75 East St	medaa Da	fra Tarr		Domlo	MD 206
0a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	milise bi		Oc. Location -		
1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State		matory or other place ${ t eld-Echols}$		7/2009	harlo	· · · · · · · · · · · · · · · · · · · ·	all, MD
4 ☐ Donation 5 ☐ Other (Specify  1. Signature of Funeral Service Licen	/			1	·			
	- tay he		2. Name and Addres					
Kyle Simons MO			22955 Holl		-			
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	one cause of each line.	death. Do not en	ter the mode of the	g, such as cardiac	or respiratory arres	St,		Approximate Interval Between Onset and Death
mmediate Cause (Final disease or condition	a Keny	ratori	1 tail	200		-7.50		day
esulting in death)	Due to Ar an a co	nsequence of)/	000					1
Sequentially list conditions	b. (2)	evral"	Eden	a				mo.
Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of .	1	0			/	~
nat initiated events	c. Care	was,	ymal	oma				$(\mathcal{U})$
esulting in death) Last	Due to (or as a co	nsequence of					(	
	d							
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	23c. If yes, outcome of p					23d. Dat	te of deliver	y
3b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐ Ectopic pregnancy					'y Day Year
3b. Was decedent pregnant	1 Live birth 2	Fetal death 3		,				•
in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 31 e of death 51	Other (specify)		23e. Did toba	Мо	onth [	Day Year
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3b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ■ No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 31 e of death 51	Other (specify)		1 ☐ Yes 24a. Was an autopsy	acco use cont	ribute to the	Day Year e cause of death ubly 4 □ Unkn sy findings avail
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3b. Was decedent pregnant in the past 12 months?  1	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown  ontributing to death but not  Hospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day, Ye	Fetal death   3   e of death   5   ot resulting in the understand   2   ER/Outpatie	Other (specify)  Inderlying cause give  Int 3 DOA Other  O	en in Part I.  26. Place of Death	1  Yes  24a. Was an autopsy perform 1  Yes  2 h (Check only one, me 5  Resider	Mo acco use cont acco use cont acco 2 No 24b. acco 24b. acco 3	ribute to the 3 Probe Were autopprior to comdeath? 1 Yes 4	Day Year  e cause of death  ably 4  Unkn  sy findings avail  appletion of cause  2  No
3b. Was decedent pregnant in the past 12 months?  1	Hospital:  2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 4 Inpatient 4 Inpatient 5 Inpatient 6 Inpatient 7 Inpatient 8 Inpatient 9 Inpatient 9 Inpatient 1 Inpatient 1 Inpatient 1 Inpatient 1 Inpatient 1 Inpatient 1 Inpatient 1 Inpatient 1 Inpatient 1 Inpatient 2 Inpatient 1 Inpatient 1 Inpatient 2 Inpatient 3 Inpatient 4 Inpatient 4 Inpatient 5 Inpatient 6 Inpatient 6 Inpatient 6 Inpatient 7 Inpatient 8 Inpatient 8 Inpatient 9 Inpat	Petal death 3   e of death 5   of resulting in the L  2 ER/Outpatie ar) 28b. Time c Injury  At home, farm, st	Other (specify)  Inderlying cause give  Int 3 DOA Other  Of 28c. Injury Work  M 1 DOA	26. Place of Death  26. Place of Death  17. 4 M Nursing Ho  18. 2 □ No	1   Yes  24a. Was an autopsy perform 1   Yes 2 h (Check only one, one 5   Resider 28d. Describe hov	Mo  acco use cont  ac	ribute to the 3 Proba Were autoporior to combeath? 1 Yes 4	Day Year e cause of death abiy 4 □ Unkn sy findings avail apletion of cause 2 □ No
3b. Was decedent pregnant in the past 12 months?  1	1  Live birth 2  4  Pregnant at tim 9  Unknown  ontributing to death but not not not not not not not not not no	Petal death 3   e of death 5   of resulting in the L  2 ER/Outpatie ar) 28b. Time c Injury  At home, farm, st	Other (specify)  Inderlying cause give  Int 3 DOA Other  Of 28c. Injury Work  M 1 DOA	26. Place of Death  26. Place of Death  17. 4 M Nursing Ho  18. 2 □ No	1  Yes  24a. Was an autopsy perform 1  Yes 2 h (Check only one, me 5  Resider 28d. Describe how	Mo  acco use cont  ac	ribute to the 3 Proba Were autoporior to combeath? 1 Yes 4	Day Year  e cause of death  abiy 4 □ Unkn  sy findings avail  pletion of cause  2 □ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and address

James P. Jarboe, 1 31. Date filed (Month, Day, Year) OCT 0 7 2009

**Physician** /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination instituted and once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

24035 Three Notch Road, Hollywood, MD Registrar's Signature

20636

use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** TOBER Paul Vincent Montgomery 2009 /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARLE IVISTA MEDICAL C APLATA 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 18,1922 Maryland January 87 219-12-4168 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f shov traumatic event, the Medical Evarrings must be notified at 1 ☐ Yes 2 No Director Charles Benedict Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō death with 20612 USA 7840 Mill Creek Road 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 Ares 2 □ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married White jo, 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Dixson Benedict C. Montgomery 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and 2 Department of Health Important: If Item 27 i any Injury or other tra once. 19329 Horsemen Place, Benedict, MD 20612 Benedict Montgomery, Jr./brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 0 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 13, 2009 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., PO Box 128, Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nours. **Physician** l disease or condition resulting in death) /Medical (or as a consequence of): 1 day Examiner MU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 \( \subseteq \text{ Ectopic pregnancy} \) Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a P.O. 9 T Hoknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ androporty 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? renal 24a. Was an performe 1 ☐ Yes 2 ☐ No 2 ANo 1 Tyes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 - ER/Outpatient 3 - DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

[ Medical Examiner: On the basis of examination and/or investigation.] 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

. Date filed (Month, Day, Year)

9 Senter B. Garles St. La Plata, MD 20646

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Carl Alfred Marks Αм October 2009 4:25 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 5110 42nd Avenue Hyattsville Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1⊠M 2□F 578-40-5300 78 June 29, 1931 Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5110 42nd Avenue 20781 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Construction 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Louis Marks Hazel Melba Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Blotner Marks / Wife 5110 42nd Avenue, Hyattsville, MD 20781 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/6/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Neoplasm Bronchus disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🔀 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner Examiner law requires that the death certificate be executed

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exerciped in a traumatic event, it is Medical Exerciped in a traumatic event, it is Medical Exerciped in a traumatic event.

Baltimore, Maryland 21215-0036

Box 68760

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Physician/Medical

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Certification:

Medical

Division of Vital Records, Hospital or Attending Physician: death. nours after death neral Director: / filled in by the fi 24 hours a To the Hosp within 24 ho To the Fune completely fi

The

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

1 X Natural

2 Accident

3 Sulcide

29a, Certifier

4 Homicide

(Check only

29b. Signature and titleof certifi€

5 Pending

investigation

determined

6 ☐ Could not be

32. Registrar's Signatu

29c. License number \$1000 (XO)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2048 1 Vernell McNeil 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegan WMHS Braddock Campus umberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min Year) 1 XM 2 ☐ F North Carolina Director 245-56-1521 71 October 29, 1937 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Allegany Lonaconing Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21539 15 Douglas Avenue USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Delivery 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Liza Campbell Ernest McNeil ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Lee McNeil - Wife 15 Douglas Avenue, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prince Cemetery Oct 14, 2009 Holly Springs, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 Lonaconing, MD 21539 8 East Main Ma 23a. Part. Enter the disease, or of inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Massire mTracyania disease or condition resulting in death) /Medical Examiner elevation my clardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension the attending physician and ned for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ▼Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and Ifile of 29d. Date signed (Month, Day, Year) D0068455 October 06, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Drive Cumberland, MD. 21502 MD. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Mildred K. Messick 0445 AM 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner alisburg 10014 PENINSULA WICOMICO If Under 1 Year | If Upder 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕱 F 220-07-2519 88 Director 03/20/1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo 28a-f Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21804 USA "natural", or items 23a 827 Little John Drive Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2**K** No Specify. ò Specify: white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Wicomico County Board than, permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic according to the property or other traumatic according to the property or other traumatic according to the property or other traumatic according to the property or other traumatic according to the property of the property o Elementary/Secondary (0-12) College (1-4or 5+) secretary/bookkeeper of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry B. Krebs Sr. Elsie Laabs ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27322 Nanticoke Rd., Salisbury, MD 21801 Newell Messick/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/5/09 Salisbury Crematory Salisbury, MD 4 Donation 5 Dother (Specify) 21. Sign whe of Fundal Solvice Clcensee Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonis /Medical Due to (or as a consequence of): Examiner Uninay trait Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Cerebro vascular and Due to (or as a consequence of) burialphysician s the burial Box 68760. Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by icate has been sig 7, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The perform Division of Vital 1 □ Yes ☐Yes 2☐No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

completely

State

(Check only one)

31. Date filed (Month

29b. Signature and title of certifie

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520, A

MI

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

068222

29d, Date signed (Month, Day, Year)

SAlisbury Md 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** 10:30 P Margaret H. McDonald 10 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NMS Healthcare Nursing Home Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/05/1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 90 Williamsport, Director 268-16-1379 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 3a or 28a-f show t be notified at 1 ☐ Yes 2 ☑ No Director Berkeley Falling Waters 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25419 USA "natural", or items 23a Rt. 1 Box 169 Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1**XX**Yes 2□ If Yes, Give Year or Dates: 2 ☐ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: White ð 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora Hope McKibbin Clyde L. Barnhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 partment of Health a portant: If item 27 k y injury or other tra Cathy Betker-POA 13202 Unger Road, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department i Important: If any injury or 4 XDonation 5 ☐ Other (Specify) WVU Memorial Vault 10/13/2009 | Morgantown, WV 22. Name and Address of FacilityWVU Human Gift Registry 21. Signature of Funeral Service Licensee P.O. Box 9131, Morgantown, WV 26506 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart **Physician** oncestin disease or condition resulting in death) /Medical Due to r as a consequence of): **Examiner** Mudcardial March Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) **To** 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident 24 hours are death 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

OCT 19 2009

31. Date filed (Month, Day, Year)

3) Registrar's Signature

CKNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.		20a. Method of Dis	position	2 DB0	moval from	e State	20b. F	Place of I	Dispos	sition (Name of natory or other	place	)		ate	20c.	Location -	City or To	wn, State	_
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that the that the the the the the the the the the th		Part II. Other signi	ficant conditio	ns cont	ributing to	death b	ut not res	ulting in t	the un	derlying cause	give	n in Part I.		23e. Dio	tobacco	use contr	ibute to th	ne cause of death?	_
equires en sig	ed by	De	ment	7 a	1	H	4/>	est	e	4715	7			1 🗆	] Yes	No	3 ☐ Prob	ably 4 □Unknowr	n
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al or A after Direct	Certification:	4 ☐ Homicide	determi	ned	buil	ding, et	c. (Specif	<i>fy)</i>	11, 3110	set, factory, offi	CC			City or T			er or mura	i Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physi Examin	cian: To the er: On the and ma	basis of	f examina	owledge, ation and	death /or inv	occurred at the restigation, in m	e tim	e, date and plinion, death	place, a occurre	nd due to thed at the time	e, date a	(s) and ma and place, a	nner as s and due to	tated. o the cause(s)	
To th withir To th comp	Me	29b. Signature and	title of certifie		7-1		,	1		29c. Lice	ense	number			29d. E	ate signed	d (Month,	Day, Year)	
		I CONC	Xuco		gh	Me	5	1		DO	00	032	3:	3	10	0-13	1-0	9	_
		30. Name and add	ress of person v		npleted cau	ise of d	eath (Iten	n 23a) (T rthc	ype, F	Ave 1	4	corch	شؤ السام الما	m	D =	اردا	2		
	ate	31. Date filed (Mor			000 32.	Registra	ar's Signa	ature 4		hand h	)	701011		411	2_0	VI / T	_(1)		
Regis	trar		VOI A	7 2	900	RA	m	Ja.	1	pare									

			. For Sta	te of Maryland / De	partment of Heal	th and Mental Hyg	jiene	0.7
			- State Registrar		ertificate of Dea		leg. No. 0 5	33:01
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	Hattie Arlene	Nedrow	di Oit Tour autoni	Octobe		
	Examin	er	4a. Facility Name (If not institution, give street a	,	4b. City, Town, or Loca		4c. County of Deat	
4	Funeral		Oakland Nursing & 5. Social Security Number 6. Sex	Rehab. Cent 7. Age (In yrs. last birthd	ay) If Under 1 Year If U	nder 24 Hrs. 8. Date of Birth	Garro	thplace (State or Foreign
	Director		215-74-5181 <sup>1□ M 2</sup>	76 Yrs	Months Days Ho	urs Min. (Month, Day NOV • 4		Maryland
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I have so marked other than "natural", or items 23a or 28a-f show umatic event, the Modical Eventing the redifficed at	ō						1 <b>X</b> Yes 2 □ No
-	the N	Director	MD Garrett  10e. Street and Number	Oak1	and 10f. Zip Code		l 0g. Citizen of What Co	untry?
7	3a or		706 E. Alder St.		21550		U.S.A.	
	death	Funeral	11 Marital Status 12. Wa	s Decedent Ever in U.S.	3. Was Decedent of Hispani	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)		
2	or ite		lf Y	ned Forces? ]Yes 2∭No es, Give	_	ecity:	Specify:	White
Ś	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Ye	ar or Dates:		T	16b. Kind of Business	
2	n /2 h	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (G	ecedent's Usual Occupation live kind of work done during le. DO NOT use retired)	most of working	16b. Kind of Business/	industry
1	withi	E O	Elementary/Secondary (0-12) Co	lege (1-4or 5+)	Handicapped	3		
2 :	other other /ent,	Be C	17. Father's Name (First, Middle, Last)			Mother's Name (First, Middle,	Maiden Surname)	
<u> </u>	uld be Ments Ments rrked rrked	일	Charles P. N	edrow		Hattie	(	Glover
g ;	2 sho 1 and 1 1s ma rauma		19a. Informant's Name/Relationship (Type. Pri	,	•	lumber or Rural Route Numbe	-	
2	and fealth m 27 her tr		Linda Ball/ Niec			nd Dr., Bel		
5	The Maryla and a should be filed within /2 hours after death with the Maryla Department of Health and Mental Hygiene. Inportant! If Item 27 is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Maryla Every income institute of once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remova	I from State 20b. Place of Di cemetery, i	sposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State
	rtmer rtant: njury		4 Donation 5 Other (Specify)	Addis	on Cemetery 22. Name and Address of F		Somerset	, PA
	Depa Impo any ii		21. Signature of Funeral Service Licensee	′		Newman Fu	ineral Ho	mes P.A.
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	tat caused the death. Do not	The state of the s	St. Grants		Approximate
	hysician		Immediate Cause (Final	e on each line.	1 fil.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	oue to (or as a consequence of):	new fallow.			1000
É	xaminer		Conventionly list conditions	Sepsia				1-ruk
3	g ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	oue to (or as consequence of):	1 1/1	2.1		1-7-le
-	and trans	Examiner	triat trittated events	Oue to (or as a consequence of):	urrent VI	120		1-6-16
5	ate be executed hysician and the burial-transit			rue to (or as a consequence or).				
	the th	edical	d					
5	attending p	N/N		es, outcome of pregnancy			23d. Date of de	livery
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	ned by the a	hys	9 ☐ Unknown 9 ☐	Unknown				
6	igned igned be de	þ	Part II. Other significant conditions contribution	ng to death but not resulting in th	e underlying cause given in I		bacco use contribute to	1.7
5	s been signers should be	Completed	7 10 1011	1/1/1/	A A	1		
ַ כ	e law has b je 2 sl	힐	hypotension,	172112 11 11011	905/5 /15/	24a. Was a autop	an 24b. Were a sy prior to med? death?	utopsy findings available completion of cause of
	r: In	- 1	ALStonia Ana	n,2, 1) out,	Blind tail	1016 NC1 □Yes	2 No 1 □Yes	2 <b>X</b> No
	sicial certi irecto	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospita	:	Other	Place of Death (Check only of		
5	a rny er this eral d	n: To	27. Manner of Death 28a	. Date of Injury 28b. Tim	e of 28c. Injury at	Nursing Home 5 Resid	lence 6 Other (Spa	ecity)
5	ath. r: Afte e fun	Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Inju	ry Work? M 1 □Yes	2 🗆 No		
2	ar decretor	tific	3 Suicide 6 Could not be determined 28e	Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or R	ural Route Number,
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	To the hospital of Attending Priystolant. The law requires that the death certificativiting 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	edical	(Check only 2 Medical Examiner: O	To the best of my knowledge, on the basis of examination and/o				
4	thin 2 the mple	Med	one) are 29b. Signature and title of certifier	d manner stated.	29c. License num	nber	29d. Date şigned (Mon	th. Dav. Year)
, i	o vit		) Shillings		HAA	1/24716	10/2/09	
•			30. Name and address of person who complete	ed cause of death (Item 23a) (Tv	pe, Print)	01100	/ /	
		3	311 N. Fourth St			r. Richard I	Porter MD	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		and the same of the same same at		
	Registr	ar	001 - % Z009	Marian A S	sarre			

Registrar DHMH 17 Rev 1/2001 State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otate of Ma	-	Certificate d				Reg. No.	009	33408	
÷			1. Decedent's Name (First, Middle, La	st)					Date of Dea Month		Voor	3. Time of Death	
	Physicia /Medic		Norma	a Nori Nall					ctober	Day	2009	5:50 P M	
Ţ	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Tow	n, or Location	n of Death		4c. C	ounty of Death		
			Howard County Ger	neral Hospi	tal.	Colum				Н	Howard		
, , , , , , , , , , , , , , , , , , ,	Funeral Director		475 20 2809	7. Age	(In yrs. last birth	nday) If Under 1 Ye Months Da		Min.	Date of Birth (Month, Day Feb 19	, Year)	Cou	place (State or Foreign ntry)	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits	
	Aaryli f sho ed at	ō	100		-11'							1 ☐ Yes 2X No	
	the N 28a-	Director	MD Howard  10e. Street and Number		ELLIC	ott City  101. Zip Coo	le		Τ.	10a. Citize	n of What Cou	ntrv?	
	with Sa or t be	Ö	3004 N. Ridge Ro	ad Ant H106	•		043			0	United	•	
	ms 2:	Funeral	11. Marital Status	12. Was Decedent E		13. Was Decedent If Yes, specify (		Origin? (Specify	Yes or No-		I. Race - Ameri	can Indian,	
212-0030	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	If Yes, specify (			an, etc.)		Black, White, Bpecify: Whi		
Ş	2 ho	ted	15. Decedent's E	ducation	16a. I	Decedent's Usual Oc	cupation	oet of working		16b. Kind	of Business/Ir	ndustry	
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	Give kind of work do life. DO NOT use re	tired)	osi oi working					
V	ed wij	S	12			<u>Homemake</u>					wn Home		
yiand	e dalla	Be	17. Father's Name (First, Middle, Last,	)			1	ther's Name (Fi		Maiden S	urname)		
yla	should be ind Ments is marked umatic ev	ဥ	Richard Nori					a Waisa					
Mar	an an is r		19a. Informant's Name/Relationship (			Mailing Address (Str						· ·	
	and ealth n 27 ner tu		Jonathan Miller/	Son		921 Old S							
9	of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of cemeters	Disposition (Name o , crematory or other	place)	Date		20c. Loca	ation - City or T	own, State	
Ē	Pag ment ant: luny		4 ☐ Donation 5 ☐ Other (Special		Ardent	Cremator		10-3-2			ver, MD		
baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Lice	nsee	101044							ily FH Inc.	
4	<b>₽</b> □ = 9		den com	- Culp						t City,	MD 21043		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do n	ot enter the mode of	dying, such a	as cardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death	
Ž.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acute Re	spirato	ry Failur	е						
1	/Medical Examiner		resulting in death)	,	consequence o								
		<u>.</u>	Sequentially list conditions,	b. Aspirati	on Pneu								
ï	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	·)·							
_	and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence o	n:							
20	icate be executed physician and s the burial-transit	a E		,	•	,							
08/00,	rificate be executed ig physician and as the burial-transit	ledical		_d									
	certif		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p						23	d. Date of deliv	verv	
.c. 60x	w requires that the death cer been signed by the attendin should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at t 9□Unknown		3 □Ectopic pregn 5 □ Other (specif					Month	Day Year	
7	that ed by deta		Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying cause	given in Par	rt 1.	23e. Did to	bacco use	e contribute to	the cause of death?	
Hecords,	requires that een signed b nould be deta	d by	Lower Gastroin	testinal	Bac	teremia			1 □ Y	es 2 <b>%</b>	No 3□ Pro	bably 4 Unknown	
5	law rec as beer 2 shou	Completed	Myasthemia Gra	ni e				-	24a. Was a	an	24b. Were aut	opsy findings available	
	sician: The law certificate has E irector, page 2 s	пď								rmed?	prior to co death?	ompletion of cause of	
VII	an: T lifficat or, pa	e Cc	Diabetes Melli  25. Was case referred to medical	tus			26 Pla	ace of Death (C		2 No	1 ☐ Yes	2 L No	
	Physician: this certific	00	examiner? 1 Yes 2 No	Hospital:	nt 2 DEB/Out	patient 3 DOA	Other				□Other (Spec	60	
0		: To	27. Manner of Death	28a. Date of Injury	/ 28b. T	me of 28c.	njury at Work?		I. Describe h			119)	
UNISION	Attending P r death. ector: After t by the funera	tio	1 Accident 5 Pending 2 Accident investigatio	(Month, Day	Year) In		Work? 1 ∐ Yes 2 l	□No					
S	l or Attendi after death. Director: A I in by the fu	ifice	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home, far	m, street, factory, of	ice	28f.			Number or Rui	ral Route Number,	
5	spital or Atours after of the ours after of the ours after of the output	Certification:	4 [Tromlade	building, etc.	(Specify)				City or Tow	vii, State)			
	Hos Fur ely	Medical (		nysician: To the best of miner: On the basis of and manner stat	examination and								
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lic	ense numbe	er		29d. Date	signed (Month	, Day, Year)	
•			Dendleya	M a -	m(	) D3	6974				10/01/2	009	
	,2		30. Name and address of person who David O. Nyanjom	completed cause of de MD 10724 I			arkway	Columb	bia, M	ID 21	044		
Ì	Sta Registr		31. Date filed (Month, Day, Year) OCT 0.5 2	32. Fegistra	r's Signature	parke							
				/	1-1	77							

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year $P^{\mathsf{M}}$ 2:50 September 2009 Oxman 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bethesda Inder 1 Year | If Under 24 Hrs. Montgomery 9. Birthplace Country) Suburban Hospital 8. Date of Birth (Month, Day, Year) (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Days Min Months Hours 1 X M 2 □ F 1905 May 15, Ukraine 104 150-10-1678 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1XYes 2 No Maryland | Garrett Park Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11115 Kenilworth Ave. Box 106 20896 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married 1 □Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Laborer</u> Laundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Drucker Benjamin 0xman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20896 19a. Informant's Name/Relationship (Type. Print) 11115 Kenilworth Ave. Box 106; Garrett Park, MD Stanford H. Benjamin/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 10/6/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, MD 20852 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator, arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death a Acute myocardial infarction 1 disease or condition resulting in death) MO Due to (or as a consequence of): b. Complications of hip fracture Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) c Fall resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? underlying cause given in Part I. osteopor

Othe

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

ns 23a or 28a-f show rust be notified at

7 is marked other than "natural", or items traumatic event, the "Medical Examiner The

Item 27 other to

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Department of H
Important: If Itel
any Injury or ott

Baltimore, 1

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Records.

Division of Vital

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Director

Funeral

Completed by

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i and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Yen 27 is marked other than "-"

/Medical

attending physician and for use as the burial-tran

Examiner

Physician/Medical

Completed by

Certification: To Be

Medical

page 2 ospital or Att.
44 hours after death.
•aral Director: After
'in by the fur

Part II. Other significant condit Chronic renal of				
Curonic fenal	arsease,	Heart	ursease,	OSLEO
dementia				
25. Was case referred to medic	al			
examiner? 1 X Yes 2 □ No	Hospital:	☑ Inpatient	2 ER/Outpatien	t 3 🗆 DOA
27. Manner of Death	28a. D	ate of Injury	28b. Time of	280

osis,	1 ☐ Yes 2 ☐	] No 3 ☐ Probably	4 ⊠ Unknown
	24a. Was an autopsy performed? 1 □ Yes 2 ☒ No	24b. Were autopsy prior to comple death? 1 ☐ Yes 2 🛣	tion of cause of
26. Place of Death (	Check only one)		
C 4 □ Nursing Home	5 □ Residence 6	Other (Specify)	

28d. Describe how injury occurred

27. Manner of Death 1 ☐ Natural 2 ☑ Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year) 9/22/2009	28b. Time of Injury 10:00 PM	28c. Injury at Work? 1 ☐ Yes	2 <b>⊠</b> No	Fall while walking
3 ☐ Suicide 4 ☐ Homicide	6 □ Could not be determined	28e. Place of Injury - At h building, etc. (Speci		ory, office		28f. Location (Street and Number or Rural Rout City or Town, State) 1801 East
	/	Nursing ho	me			Apt 237; Rockville, MD
29a. Certifier	1 / Certifying Phys	ician: To the best of my kno	owledge, death occurre	ed at the time, o	late and plac	e, and due to the cause(s) and manner as stated.

Fall while walking 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1801 East Jefferson Apt 237: Rockville, MD 20852

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number 066066

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person with

Word 8600 Old Georgetown, Road, Bethesda, MD 20814

State Registrar 31. Date filed (Month, Day, Year) OCT **U**5

To the Hospital
within 24 hours a
To the Funeral I
completely filled

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Ам 3:43 James Richard Owens 2009 October 8, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Leonardtown St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 □ F Yrs. 82 216-22-2755 May 7, 1927 Director Maryland Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is included. 10a. State 1 x Yes 2 □ No Director Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 42096 Medley's Neck Road 20650 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Residential Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Benjamin Franklin Owens, Sr. Mary Frances Wilkinson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26675 Marion Drive Mechanicsville, MD 20659 Carolyn L. Nelson / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 9 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia 2009 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service Licensee Kennett Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Ro 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♠ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ho completed caus of death (Item 23a) (Type, Print) Patrick James Jarboe, M.D. 30. Name and addres Leonardtown, MD 20650 21585 Peabody Street 32 Registrar's Signature State Registrar

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		For	State	of Mary		•			d Mental H	lygiene	e2000	3341	
		1 - State Registrar				Certific	cate of	Death		Reg. No	).		
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/Medic		Stella Jeann			Peck						, 200 <sup>9</sup>	8:35 A M	
Examin	er	4a. Facility Name (If not institution, g						or Location of De	ath		. County of Death		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination use to collided at once.		19a. Informant's Name/Relationship Roy Peck/Son	(Type. Print)								or Town, State, Z yland 20		
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Division of Vital Records, P.O. Box 68760, 👉

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours of To the Funeral completely filled 20

> State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of

30. Name and address of po

MD 11125 Rockville Pike Rockville, Maryland 20852 Jan Bachowski 31. Date filed (Month, Day, Year) 05 2009

ted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D35370

29c. License number

29d. Date signed (Month, Day, Year)

October 1, 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 Minnie Gertrude Potter October 10:50 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ★ F 223-26-3670 Director 86 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Expression resist be notified at Director Maryland Cecil 1X Yes 2 □ No Perryville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 332 Front Street 21903 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X☐ No Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, the 1th 20nes. Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Personal Residence Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Walter N. Williams (maiden name unknown) Jettie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Potter (Daughter) 332 Front Street, Perryville, Maryland 21903 20a. Method of Disposition 20c. Location - City or Town, State West Chester. 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State R.A. Ferris & Co., Ind. 10/03/09 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 21. Signature of Funeral Service-Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATORY **Physician** disease or condition resulting in death) /Medical Due to ( r as a consequence of): Examiner Bowel Sequentiany life conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **Z**-No 1 □Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 2 Accident 1 ☐ Yes 2 ☐ No

requires that the death certificate be executed

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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sate has been signed by the page 2 should be detached

certificate

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State

DHMH 17 Rev 1/2001

Registrar

3 Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501

6 ☐ Could not be

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5. UNION

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HAVre de GRACE, MD 21018

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#10b\_PerFHPCC10-6-09cr Certificate of Death Rea. No. 1. Decedent's Name (First, Mid-2. Date of Death Month October **Physician** 2009 Gloria Jean Phillips 8:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bedford Court Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 12 F Director 82 577-32-7827 9/30/1927 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Montgomery Prince Georges Director MD Takoma Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8108 Chester Street 20912 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ⋧ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnes." Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank O'leary Davis Gertrude Tapscott 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Boxness / Daughter 2319 Grove Lane Cary Illinois 60013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/07/2009 | Brentwood, MD Fort Lincoln 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funer Licensee 23a. Fart 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Parkinson Disease 7 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O, Box 68760, attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death ☐Yes 2 XNo 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate performed' 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only

within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

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29b. Signature and title of certifier

Arthur Schoengold, M.D. 18111 Prince Philip Dr., T -10 Olney, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D18726

29d. Date signed (Month, Day, Year)

October 5, 2009

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760 ficate g phys		F FEMALE: 3b. Was decedent pregnant in	23c. If yes, outcome	e of pregna	ncy	etal death 3	Ectopic pregr		23d. Date of Month	delivery Day Year
x 68 h certi tendin	<u> </u>	past 12 months?	4 Pregnant at ti	me of death		ther (Specify)			No.	
Bo te deat the at	Physician/wed		Jnknown 9 Unknown		data a tarahar		sives in Dort I	23e Did t	obacco use contri	bute to the cause of death?
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	<u>ה</u>	Part II. Dther significant con	ditions contributing to death	but not rest	uiting in the	underlying cause	gi <b>ve</b> ii iii Fait i.			Probably 4 Unknown
ds, last	Completed				-			24a. Was		Vere autopsy findings available
COF	ᇍ							auto perfo	ormed?	orior to completion of cause of leath?  Yes 2 No
r: The		25. Was case referred to med	ical			26.Piac	e of Death (Chec		2 10 1	103 2 110
Vital Rechysician: The this certificate I director, page	o Re	examiner?	No. 10 To the least of the leas	nt 2 🗸 E	R/Outpatien	nt 3 DOA	Other Nurs	ing Home 5	Residence 6	Other:
n of ing Ph After t funeral	-1	27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y 2 ar)	8b. Time of		ury at Work?	28d. Describe	how injury occurr	red
VISION or Attendi	를 		ending vestigation Fd 10/11			0 am	Yes 2 X No		(0)	Dural David Number City
ivis for A after Direction	Certification:		ould not be etermined (Specify) for			eet, factory, office dence	building, etc.	or Town, Thurmo	State) 104 B	er or Rural Route Number City Frederick Rd
lospita Hours unera		4 Homicide	Physician: To the best of my				late and place, a			r as stated.
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burity of the funeral director.		(Check only 1 Certifying one) 2 Medical E	xaminer: On the basis of examiner and/manner stated.	nination and	dor investiga	ation, in my opinio	n, death occurred	at the time, date	e and place, and o	due to the cause(s)
7 00 100 000 000 000 000 000 000 000 000	ĕŀ	29b. Signature and title of cer		1/28	241	29c. Licen	se number			ed (Month, Day, Year)
		( web 2	faller feel			0.0	.M.E.		October 12	2, 2009 
0	t		son who completed cause of de			Donn Street	Poltimore M	D 21201		
V		Victor Weedn MD J				Penn Street,	paiumbre, M	U Z 1ZU1		
Sta Registr	_	31. Date filed (Month, Day, Ye	F' 6 0000 WI	's Signature	A. As	arke				

DHMH 17 Rev 1/2001 OICME 2006

Registrar

	•	State Registrar	aryland / Dep Ce	artment of I rtificate of I			giene Reg. No.	33415
Physicia Medic		1. Decedent's Name (First, Middle, Last)  MARYLIN C. ROACH				2. Date of Dea	2 <sup>Day</sup> 2009 <sup>Year</sup>	3. Time of Death <b>1:25 A</b> M
Examine	er	4a. Facility Name (if not institution, give street and number)  HOSPICE OF QUEEN ANNE'S		CEN	NTREVILLE		4c. County of Dea	ANNE S
Funeral Director		5. Social Security Number 118–16–9832 6. Sex 1 M 2 XF 7. Age 1 M 2 XF 7. Age 10 M 2 XF 7. Age 11 M 2 XF 7. Age 11 M 2 XF 7. Age 12 M 2 M 2 XF 7. Age 12 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2	(In yrs. last birthday)  84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 13		thplace (State or Foreign untry) <b>YORK</b>
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County  MARYLAND QUEEN ANNE'S	10c. City, Town or Lo	CHESTER				10d. Inside City Limits 1 ☐ Yes 2 🗶 No
th the	a D	10e. Street and Number	<del></del>	10f. Zip Code			10g. Citizen of What Co	ountry?
ath will	nner	415 TEAL COURT  11. Marital Status 12. Was Decedent E			21619	- 1 V N	UNITED S	
Maryland 21215-0036 2 should be filed within 72 hours after deith and Mental Hygiene. 27 is marked other than "natural", or ite traumatic event, the Medical Examine.	þ	1 Never Married 2 Married 3 M Widowed 4 Divorced 12 Was Deceded 12 Armed Forces? 1 Yes 2 1 1 Yes, 3 1 Yes or Dates.	NO WITT	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, Whit	
15-(	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of work	king	16b. Kind of Business	Industry
vithin iene.	် ပ	Elementary/Seconday (0-12) College (1-4 or 5-	+) life, D	O NOT use retired) HOMEMAK			OWN HOM	r.
filed vall Hyg	Be	17. Father's Name (First, Middle, Last)		HOTILIAN		ne (First, Middle, M		<u> </u>
ylar Id be Menta arkec	ှ	JOSEPH GRAHAM CHAPMAN			MARY LOT	JISE FULI	LER	
b, Marund 2 shou lealth and m 27 is m her traum	ĺ	19a. Informant's Name/Relationship (Type, Print)  BONNIE R. MEADE/DAUGHTER					City or Town, State, Zi	p Code)
Baltimore, cermit. Page 1 and Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 🕹 🗀 Sther (Specify)	20b. Place of Dispo cemetery, crer CHESAPEAK	natory or other plac E_CREMAT] NTER	ION OCTO	BER 3,		LE, MARYLAND
Bal permi Depa Impo any ir	ļ	21. Signature of Fune A Service Licensee	Fec F	Name and Addre	ss of Facility FEL OME, P.A.	, 106 SH	LFENBEIN & AMROCK ROA RYLAND 216	D. CHESTER
Ph sician/ Medical Examiner  Style paragraphs  S	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of initions that initiated events to c.			g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
box 68 death certif e attending ed for use a	₹	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of the past 12 months?  4  Pregnant at 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	гу		23d. Date of de Month	ivery Day Year
To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	≧	Part II. <b>Other significant conditions</b> contributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.	1	acco use contribute to	the cause of death?
al or Attending Physician: The law requires s after death. I Director: After this certificate has been signal in by the funeral director, page 2 should by the funeral director.	completed	25. Was case referred to medical				24a. Was ar autops perform 1 \(\sum \) Yes 2	y prior to o	topsy findings available completion of cause of
VIITA /sicia /siciti	0 06	examiner?	nt 2 🗆 ER/Outpatien	Othe	ace of Death (Checi			11 12 5
on or anding Phy ath. r: After this ne funeral o		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day,	28b. Time of	28c. Injury work	/ at	28d. Describe how	nce 6 Other (Spec w injury occurred	fy) HSJ/1CE
ital or Atte urs after de al Directo led in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
the Hosp hin 24 hou the Funer npleted fill	Medical	29a. Certifier (Check conly one) Certifying Physician: To the best of many one) Certifying Nurse Practioner: To the basis of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: To the basis of examiner: On the basis	mination and/or invest	igation, in my opinio	n, death occurred at	t the time, date and	place, and due to the o	ause(s) and manner stated.
V Wit		29b. Signature and title of certifier		29c, License			Oct See 1	
	[	30. Name and address of person who completed cause of dea						
State	3	31. Date filed (Month, Day, Year)  32. Registrar	s Signature	MD 216	66			
Registrar		31. Date filed (Month, Day, Year) 32. Registrar OCT 0 2 2009	a B. A	bare				

			1 - For State Registrar	State	of Marylar			of Health and I of Death		giene Reg. No.	109	33415
		र्ष इ	Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath	Vana	3. Time of Death
	Physic /Medi		Catherine Ma	arie Re	eadmond				October	Day 2	009	11:00 p.M.
	Examir	ner'	4a. Facility Name (If not institution,		ımber)		4b. City, Tov	wn, or Location of Death	n	4c. Co	unty of Death	1
	¥ <u>II</u> II	15	St. Mary's Hosp: 5. Social Security Number	ital 3. Sex	7 4 //	do no filippo de la	Leonar	dtown 'ear   If Under 24 Hrs.	8 Date of Bird		Mary'	
	Funeral Director		215-36-5103	1 □ M 2 💢 F	7. Age ( <i>in yrs</i> .	Vec		ays Hours Min.	8. Date of Birt (Month, Day 03/08/1	y, Year)	Cou	nplace (State or Foreign untry) Land
			Usual Residence of Decedent		/ / /				03/00/1	.930	mary	Tanu
	larylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	after death with the Maryla or Items 23s or 28s-f shor nirer nast be recilled at	Director	Maryland St. Mar	y's	Ho1	lywood	T					1 ☐ Yes 2 X No
	with t		10e. Street and Number				10f. Zip Co				of What Cou	
	death	Funeral	24304 Mervell De		sedent Ever in U	I.S. 13.	20636 Was Decedent	6 of Hispanic Origin? (S	pacify Yas or No-	United	State	es ican Indian
ထ	after o		1 Never Married X Marrie	d Armed F	orces? 2 <b>X</b> No		f Yes, specify	Cuban, Mexican, Puert	o Rican, etc.)		Black, White	
93	ral', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1□Yes 2Å	No Specify:		Spe	ecity: Whi	ite
5-0	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28s-f show event. It a Modical Examiner must be motified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	)	(Give	dent's Usual O kind of work d	one during most of wor	king	16b. Kind o	of Business/I	ndustry
12	d withir jiene. r than Ir e M.	dmo	Elementary/Secondary (0-12)	College (	1-4or 5+)	Homem	DO NOT use n	etired)		O 11		
d 2	be filed ntal Hygie nd other evant. II		17. Father's Name (First, Middle, L.	 ≘ <i>st)</i>		nomem	aker	18. Mother's Nan	ne (First, Middle,	Own H		
<u>a</u>	lid be lental kad c	To Be	Charles Aubrey G	ravec							,	
Maryland 21215-0036	shou and M s mar	-	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (St	Mary Fra			wn, State, Z	ïp Code)
	es 1 and 2 should be fil of Health and Mental H i itam 27 Is markad ott r othar traumatic evan		Joseph L. Readmo	nd/Husba	nd	24304	Merve]	ll Dean Roa	d. Holly	wood.	MD 2	20636
altimore,	of He of He fitan		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	I □ Bernoval from		Place of Dispo	sition (Name o	of	Date	20c. Locati	ion - City or T	own, State
<u>Ë</u>	permit. Pages Department of H Important: If its any injury or of		* 4 □ Donation 5 □ Other (Spe		St.	John'	s Ceme	tery 10/0	7/2009	Hollyv	wood.	Maryland
Ball	permit. Departr Imports any inju		21. Signature of Funeral Service Li	censee	Jan	22	. Name and A	ddress of FacilityBri	nsfield	Funer	al Hon	ne, P.A.
	005 # O	$\vdash$	Kyle S. Simon			2	2955 Ho	ollywood Ro	ad, Leon	iardto	wn, Mr	20650
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	ny one cause on o	each line.							Approximate Interval Between Onset and Death
	Prrysician /Medical	7. (	Immediate Cause (Final disease or condition resulting in death)	a			CASZD	IAL INT	ARC-TI	220		
	Examiner			Due to	or as a conseq	luence of): LC ( C L L	-2071L	CARDIO	1/200 W	me i)	ومعتري	316000
	_ & E	er	Sequentially list conditions, if any, leading to immediate	D	(or as a conseq		20170	- 10-10/10	V193 C 0 4	-178-111	is the	y GAG
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		DIABE	TES	MELL	1705				YEARY
, O	be executed sician and burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):						
876	cate be executed obysician and the burial-transit	dlcal		d								
011 0x 68		Med	IF FEMALE:	"						-		
7 ¢ Bo	death certifi e attending i id for use as	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna pirth 2 Feta	Ideath 3□	Ectopic pregn			23d.	Date of deliv Month	very Day Year
0,5		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟ Pregr 9⊟ Unkn	nant at time of d lown	eath 5L	Other (specif)	y)				
, P.		y Ph	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the ur	nderlying cause	given in Part I.	23e. Did to	bacco use d	contribute to	the cause of death?
Sp.	v requires been sign should be		17410	TENS	אדט ד				1 □ Y	es 2 🖼 🕏	ర్ 3∐Pro	obably 4 🗆 Unknown
7 0		Completed							24a. Was a	an 24	4b. Were aut	opsy findings available
Rec	ti <b>cian</b> : The lav certificate has rector, page 2	mo							autops perfor	med?	prior to co death? 1  Yes	opsy findings available ompletion of cause of
<u> す</u> <u> 国</u>	ian: ortifica ctor, p	Be C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes th (Check only or		1 1 105	2 140
25	Physician: this certific	To	examiner? 1 ☐ Yes 2 ☑ No			ER/Outpatien	t 3□ DOA	Other	ome 5 Resid		Other (Speci	ify)
20	ding Phys	on:	27. Manner of Death  1 ☑ Natural 5 ☑ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. i	Injury at Work?	28d. Describe h	ow injury oc	curred	
tisio	tend death tor: / the f	Certification;	2 Accident investiga 3 Suicide 6 Could no	he				1 ☐ Yes 2 ☐ No				
A N	after of Dirac	ertif	4 Homicide determin	ad 286. Place	of Injury · At ho ing, etc. (Specif	ome, farm, stre y)	eet, factory, off	ice	28f. Location (S. City or Tow	treet and Ni n, State)	umber or Run	ral Route Number,
5	To tha Hospital or Attending Physician: The within 24 hours after death.  To tha Funaral Diractor: After this certificate his completely filled in by the funeral director, page	2	29a. Certifier 1 Certifying	Physicien: To the	a bast of my kno	wledge death	occurred at th	ne time, date and place	and due to the c	eauco/c) and	mannar as	etatod
	a Hos a Fur letely	edical	(Check only 2 Medical E)	aminer: On the b	asis of examina ner stated.	tion and/or inv	estigation, in r	ny opinion, death occur	rred at the time, d	date and place	ce, and due t	to the cause(s)
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title o certifier		V2		1	cense number	2	29d. Date sig	gned (Month,	. Day, Year)
	/		1 / Jun		n	D		56076		10	)-3-	09
8	10		30. Name and address of person wi			23a) (Type,	Print)					
_	N		KAJBNDE		GILL		ARYS	HOSPITAL	- LEOT	N 78-).	TONA	1, MD
	Sta Registr		31. Date filed (Month, Day, Year) 0CT 0 7 20(	19 Gened	Registrar's Signa	ture	20					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sept.30,2009 9:15am M Blanca Lidia Reyes /Medical 4a. Facility Name (If not institution, give street and number) 4h City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth 3/15/1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Hours Min. EI Salvador 85 229-67-4707 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Midical Evan it at must be notified at MD Montgomery Silver Spring Director 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Cltizen of What Country? 2202 Westview Drive 20910 Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <sup>No</sup> Specify: El Salvadoran 1 XYes 2 No þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other traumatic event injury or other event injury Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tomas Reyes Matilde Rubio 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20121 14004-C Franklin Fox Dr. Centreville, Va Hector Manuel Reyes/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 10/0792009 15 Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify Jardines Del Golfo LaUnion, El Salvador neral Service Lic PHYLEPP ADDES RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Par 1. Enter the discussion is ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARCINOSARCOMA ENDOMETRIUM disease or condition resulting in death) 18TASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 PERTENSION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed INPRIES MEILITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 □ Ýes 1 ☐ Yes 2 ☐ No 2 **1** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death

Director: A in by the f 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certified 29c. License number 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. COVARRUBIAS P.MO 8121 GEORGIA AUE #405
onth, Day, Year) 32/Registrar's Signature 31. Date filed (Month, Day, Year) State 02 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day Year BERTHA REEVES SEPTEMBER 28, 2009 2253P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 579-34-6228 10-26-1923 **VIRGINIA** Usual Residence of Decedent death with the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho MD CHARLES WALDORF 1 XYes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 2411 BERRY THICKET 20603 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 27 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: ≥ Specify: BT.ACK 3√2 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, It o Medic once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) GOVERNMENT Elementary/Secondary (0-12) HOUSEKEEPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 MANLEY D. YOUNG NANNIE E. JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THESSEL REEVES JR/SON 2411 BERRY THICKET CT WALDORF, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FIRST MT. OLIVE BAPT. 10-6-2009 NEWTON, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ATRIAL FIBRILLATION and burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical HYPERTENSION the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 X No Month Year 4 Pregnant at time of death Day 5 Other (specify) P.0. the 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate perform Division of Vital 1 ☐ Yes 2√□ No 1 ☐ Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 14 Natural 5 Pending death. Investigation 1 □ Yes after death

Director: A 2 Accident 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ie Funeral Dietely filled i 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005606 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State Registrar

KANWALJIT NAJI, MD 1500 FOREST GLEN RD SILVER SPRING, MD 20910 31. Date filed (Month, Day, Year) OCT 0 8 2009

			1 _ State	of Maryland / De	partment of F ertificate of		•			20113
	16		Registrar  1. Decedent's Name (First, Middle, Last)		ertinicate or	Dealii	2. Date of De	Reg. No.	119	3. Time of Death
	Physici /Medi		John N. Sewell, III				Septemb	per 26	2009	11:30 P <sup>M</sup>
)	Examir		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, o	r Location of I		4c. County		
			Manor Care		Potoma				ntgome	
	Funeral Director		5. Social Security Number 218-30-9615  6. Sex 1 ▼ M 2 □ F	7. Age (In yrs. last birthda 72 Yrs.	Months Days	Hours	Min. 8. Date of Bir (Month, Date of Grant of Gra	ay, Year)	9. Birthplac Country Mary1	
	fand ow rt		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d	I. Inside City Limits
	Mary H sh	to	Maryland Montgomery	Gai	ithersburg					1X Yes 2 No
	th the	irec	10e. Street and Number	, Jan	10f. Zip Code			10g. Citizen of \	What Country	1?
	23a ust b	ra L	10103 Kindly Court		2088	6		Unite	d Stat	es
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	Armed F	2 No 1954-	<ol> <li>Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No</li> </ol>	lispanic Origir an, Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Blac	ce - American ck, White, etc y: <b>Blac</b>	2.
21215-0036	2 hou atura cal E	ed	15. Decedent's Education	16a. Dec	cedent's Usual Occup	ation		16b. Kind of B	usiness/Indus	strv
215	J within 72 ho giene. r than "natu the Medical	Completed	(Specify only highest grade completed Elementary/Secondary (0-12) College	(Gi (1-4or 5+)	ive kind of work done  a. DO NOT use retired	during most o d)	f working			···· ,
7		Som	12	(1 101 01)	Lab Techn	icían		Govern	ment	
pu	I be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last)				Name (First, Middle	, Maiden Surnan	ne)	
₹	ould be a Mental narked o	မှ	John Sewell II				ce Jones			
, Maryland	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic	r į	19a. Informant's Name/Relationship (Type. Print)  Terry Sewell / Son		ailing Address <i>(Street</i> 74 <b>Panoram</b>					ode)
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from	20b. Place of Dis	sposition (Name of rematory or other place	ce)	Date	20c. Location -	City or Towr	n, State
Ē	Pages Iment of I tant: If ite		4 ☐ Donation 5 ☐ Other (Specify)	Stauffer	Cremator	y !	9/30/2009			Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee St	auffer	-	sumtown	n Pike, Fr			
0	Physician	8 1	23a. Fart1. Enter the disease, or complications that shock or heart failure. Let only one cause on immediate Cause (Final disease or condition a.	causelille death. Do not e each line. Myocardial I		ig, such as ca	ardiac or respiratory a	rrest,	10	pproximate nterval Between Inset and Death Mon LnS
	/Medical Examiner			(or as a consequence of): Arrythemia						month
坐		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):						
	ecute and trans	Examiner	that initiated events	Myocardopath	ıy					month
68760,	ficate be executed physician and s the burial-transit	JE E	Due to	(or as a consequence of):  Congestive H	Heart Fail	ure				Months
387	cate physi the b	dical	d	00118000010						
.O. Box (	death certi e attending d for use a	Physician/Me	in the past 12 months?	23c. If yes, outcome pf pregnancy  1					23d. Date of delivery Month Day Year	
Δ.	that t ed by detac	/ Ph	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause give	en in Part I.	23e. Did t	obacco use cont	ribute to the	cause of death?
Division or Vital Records,	The law requires that the de ate has been signed by the a sage 2 should be detached	d by	Peripheral Vascular	Disease			1	Yes 2 □ No	3 ☐ Probab	ly 4 Unknown
000	aw rec s bee 2 shou	Completed					24a. Was	an 24b.	Were autopsy	y findings available
Ä	The lav	шо					— autoj perfo 1⊟ Yes	rmed? /	prior to comp death? 1 □ Yes 2[	letion of cause of
ita	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?			26. Place of	Death (Check only o		10103 21	
7	Physician: r this certificaral director, p	2	1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outpati		4 M Nursi	ng Home 5 ☐ Resi	dence 6 □Oth	er (Specify)	
UC C	ding P. After I	on:	· Entatata C C Tortaing	of Injury 28b. Time onth, Day Year) 28b. Time Injury	/ Worl			how injury occurr	red	
Sic	Attending or death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 288 Place	a of injury. At home form		Yes 72∕⊡No				
<u>≥</u>	after a	Certification:	determined 200. Flac	e of injury ~ At home, farm, s ling, etc. <i>(Specify)</i>	street, factory, office		City or Tou	Street and Numb vn, State)	er or Hural H	loute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Co	29a. Certifier (Check only one) (Check only one)	dasis of examination and/or	ath occurred at the tir investigation, in my o	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and ma	anner as state and due to th	ed. ne cause(s)
	To the within 2 To the complete	Mec	29b. Signature and title of certifier	nner stated.	29c. License	e number		29d. Date signed	d (Month Da	v. Year)
			KT	0.,	DIC	1609	?	9/29/20		,, ,
•	10%		30. Name and address of person who completed cau	se of death (Item 23a) (Type	e, Print)	00/		012012		
	DR		Raman Tuli, MD 10810 D			02, Ga:	itherburg,	MD 208	78	
	Sta Registr		31. Date filed (Month, Day, Year) 32.	Rigistrar's Signature	harked					

_			1 - For State Registrar		State of	r Marylan		rtificate of	Death	, ,	lene eg. No.	110	33421
	Physic /Medi		1. Decedent's Nam		<sub>e, Last)</sub> Marge Malk	e Steri	n			2. Date of Deat Month 09	h Day <b>29</b>	2009	3. Time of Death 11:20 pm
-	Exami			If not institutio	n, give street and nun				r Location of Death		4c. Cour	nty of Death	
1	Francis		5. Social Security N	Hebrew lumber		7. Age (In yrs.	last hirthday)	If Under 1 Year	Cockville If Under 24 Hrs.	8. Date of Birth		Montgo	
	Funeral Director		565-76-	0050	1 □ M 2 <b>½</b> F	96	Yrs.	Months Days	Hours Min.	May 02,	Year)	Ro	place (State or Foreign htry) <b>mania</b>
	yland now		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	e Mar la-fsh	Director	MD	Mon	tgomery			Be	thesda				1 ☐ Yes 2 <b>X</b> No
	or 28	Dire	10e. Street and Nut	mber			_	10f. Zip Code		1	0g. Citizen o	of What Coun	itry?
	s 23a	ra	7012	Hopewo	od Street				20817			u.s.	.A.
Baltimore, Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Modeal Even ing "nest be notified at	d by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ied Armed For	2 <b>X</b> No e		Was Decedent of H fYes, specify Cuba 1 □Yes 2 💆 No	dispanic Origin? (S <sub>I</sub> an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		ace - Americ lack, White, e cify:	
15-	"natu	lete	(Spec	15. Deceden	t's Education st grade completed)		16a. Deced	dent's Usual Occup kind of work done	oation during most of world)	king	16b. Kind of	Business/Ind	dustry
212	d withir giene. rr than	Completed by	Elementary/Seco	ndary (0-12)	College (1-	-4or 5+)	lite. L	DO NOT use retired Homemak	*			Own	Home
P	e filed al Hyg d othe	Bec	17. Father's Name	(First, Middle,	Last)				18. Mother's Nam	ne (First, Middle, N	Maiden Surna	ame)	-
<u> </u>	ould to Meni	2			Arie Adle	r				Gita Lea			
Ma	nd 2 sk ulth and 27 is n		19a. Informant's Na	ame/Relations Stern			1	-	and Number or Ru L <b>Street,</b>				,
ē,	s 1 ar of Hea item (		20a. Method of Disp		- 30h	20b. P		sition (Name of natory or other place				n - City or To	
<u>.</u>	Page nent o int: If iry or		1 🗶 Burial 2 [ 4 🗆 Donation	☐ Cremation 5 ☐ Other (S	3 ☐ Removal from S becify) —	iale		m. Gardes	:	1/2009	Olnei	u Mar	uland
Balt	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, The Modest Once.		21. Signature of Fu	neral Service	Lidensee	Dir.	22	. Name and Addre	ss of Facility <b>Hi</b>	nes-Rinal	ldi Fu	neral	Home, Inc. g, MD 20904
	Physician /Medical Examiner	ər	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or br art failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a										
1 E KN x 68760, O	sertificate be executed ding physician and se as the burial-transit	/Medical Examiner	Sequentially list cor if any, leading to im cause. Enter Unide Cause (Disease or that initiated events resulting in death) L	.ast	c	or as a consequ	ence of):						
E ST 9.0. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use a	Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 Unknown	months?		rth 2  Fetal ant at time of de	death 3 [	Ectopic pregnanc   Other (specify)	у			ate of delive Month	ory Day Year
RECORDS, I	w requires that been signed should be det	ρ	1		ns contributing to dea			derlying cause give	en in Part I.	23e. Did tob		-	e cause of death?
A A A A N Vital Rec	iclan: The law certificate has I rector, page 2 s	e Completed	25. Was case referr	ed to medical						24a. Was an autopsy perform 1 □ Yes 2	ned?	prior to cor death? 1 ☐ Yes	psy findings available inpletion of cause of
₹ <b>Ξ</b>	ysici is cer direct	O.	examiner?		Hospital: 1 🗆 In	patient 2 🗆 E	EB/Outnatien	Othe	er: i	th <i>(Check only one</i> ome 5 ☐ Reside		thor (Oif	
$\wedge$ Division of	ending Physiath.  or: After this he funeral dir	ation: T	27. Manner of Death Natural 2 Accident	5 ☐ Pending investig	28a. Date of (Month)		28b. Time of Injury	28c. Injury Work	y at	28d. Describe hor			2
Divis	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, is	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determi	ned 28e. Place of building	g, etc. (Specify		et, factory, office		28f. Location (Str City or Town,	, State)		
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)	1 Certifyin 2 Medical I	g Physician: To the b Examiner: On the bas and manne	sis of examinati	vledge, death ion and/or inv	occurred at the ting restigation, in my of	ne, date and place, pinion, death occur	, and due to the ca red at the time, da	ause(s) and rate and place	manner as st e, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and t	title of certifier	Pate	lnin	9-	29c. License	1808(	/ 29 SA	od. Date sign	ned (Month, L	20 20 A 9
			30. Name and addre	ess of person v	who completed cause	of death (Item	23a) (Type, F	Print) MONT	TRACE R	P. Rozzi	1/11/15	Mo	2080
	Sta Registra		31. Date filed (Monti	h, Day, Year)	nna 2. Ré	gístrar's Signatu	ure_	4.8		1.0-0	1	1	0032

			1- State Registra MEND#8 per FH, 10/2/09, BW, MCO C	<b>03/ባኒቲ/፲20፲/<u>0</u>8ዚ</b> ክ and i e <i>rtificate of Death</i>		ene 009	33421	
	Physic		1. Decedent's Name (First, Middle, Last) Melida Garmend Melida Sorto	ez Sorto	2. Date of Death	9 <sup>Day</sup> 2009 <sup>Year</sup>	3. Time of Death 2225 M	
and .	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Montgomery		
	Funeral Director		Washington       Adventist         5. Social Security Number unk -       6. Sex 1	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		_	place (State or Foreign	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show out, If a Medeal Exaction must be conflict at	Funeral Director	Usual Residence of Decedent  10a. State	Location Spring  10f. Zip Code			10d. Inside City Limits 1 □ Yes 2 ᠯ No	
	23a or	ral Di	109 Ritchie Avenue	20910		El Salvad		
900	be filed within 72 hours after death with the Marylar that Hygiene.  id other than "natural", or items 23a or 28a-f show event, I'm Meden Exactions must build filed at	by Fune	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:	s. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1⊠Yes 2□No Specify: El Salva		14. Race - American Indian, Black, White, etc.  Specify: White		
21215-0036	within 72 ho iene. • <b>than "natu</b> i	Completed by	(Specify only highest grade completed) (Gin	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) memaker	16	b. Kind of Business/In	·	
$\subseteq$		To Be C	17. Father's Name (First, Middle, Last) Juan Antonio Viera		e (First, Middle, Ma Garmend			
	and 2 should ealth and Mer n 27 is marke ner traumatic	·	19a. Informant's Name/Relationship (Type. Print)  Diego Sorto/Husband  19b. Ma 109	ling Address (Street and Number or Run Ritchie Avenue	Silver	Spring, N	1d20910	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		Muni	position (Name of ematory or other place) rio El Carmen cipal		c. Location - City or To LaUnion, E	own, State El Salvado	
Ba	permit Depar Impor any in		21. Signature of Fineral Service Licenses	ATCIPADERINALDI 241 Columbia Bl	FUNERAL vd.Silve	L SERVICE er Spring	F,P.A. g,Md20910	
1	Physician / Medical Examiner  sthe purial-transit sthe purial-transit sthe purial-transit sthe purial-transit sthe purial-transit sthe purial-transit states and states are states and states are states and states are states and states are states are states and states are stat	cal Examiner	23a. Pan1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to inninediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	ic Grokery Ar	1		Approximate interval Between Onset and Death	
POX	death certi e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5		23d. Date of delivery Month Day Yea			
cords, F	requires that the leen signed by the nould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	ne cause of death?	
Hec	an: The law re tificate has be tor, page 2 sho	Be Completed	25. Was case referred to medical	OS Place of Park	24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of	
5	tending rnysician: Jeath. tor: After this certific the funeral director.	Certification: To B	examiner?  1 GYes 2 No  Hospital: 1 Inpatient 2 Re/Outpatie 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be	ent 3 DOA Other: 4 Nursing Ho  of 28c. Injury at Work?  M 1 Yes 2 No	m (Check only oné) me 5 ☐ Residenc 28d. Describe how i	e 6  ☐ Other (Specifinjury occurred	y)	
	within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.		29a. Certifier  29a. Certifier  Check calculations and determined determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)  29a. Certifier  Check calculations and determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		City or Town, S		·	
100	thin 24 h	Medical	one) wedical Examiner: On the basis of examination and/or i	nvestigation, in my opinion, death occuri	ed at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)	
)	4		29b. Signature and title of certifier  Co. No.	29c. License number 5 2 3 2 6	9	Date signed (Month,		
			30. Name and address of person who completed cause of death (Item 23a) (Type James K. Lightfoot M.D. 7600	Carroll Avenue	Takoma	Park, Md	•	
	Stat Registra		31. Date filed (Month, Day, Year)  OCT 02 2009  32 Registrar's Signature	wed				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year SNIPES ELIZABETH OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S DOCTOR'S HOSPITAL **LANHAM** 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1 □ M 2 🖺 F Months 78 Director 453-40-5244 24 1930 TEXAS Usual Residence of Decedent with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, Ite Madical Extrair or must be mothed at Director MD PRINCE GEORGE'S BOWIE 1 No 2 No 10e. Street and Number 10f. Zip Code 10g. Citizeп of What Country? death v 3507 VISTA VERDE DRIVE Funeral 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DOMESTIC 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM SNIPES ဂ **EDNA** WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILMA E. PERSAUD/DAUGHTER 3507 VISTA VERDE DRIVE BOWIE, MARYLAND 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-10-09 EVERGREEN CEMETERY AUSTIN, TEXAS 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a co. auence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of Box 68760, Physician/Medical the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 mon 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. ed by the detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 / No 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \(\sum \) Nursing Home Certification: To 1 Inpatient this 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of After Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 | Pending investigation 1 ☐ Yes 2 No hours after death uneral Director; filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the

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Registrar

29b. Signature and title of certifier

Year)

30. Name and address of pe Hozia 31. Date filed (Month, Day,

UCT 0 @ 2009

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

		1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygiene  Reg. No. On No.				
Physic /Medi		1. Decedent's Name (First, Middle, Las Gilbert F. Snea	ad, Sr.		2. Date of Death Month Day Year 10 1 2009 6:15				
Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea					
		2729 Patuxent Riv		Davidsonvill	TITUTE TITUTE				
Funeral Director		578 <b>-</b> 05 <b>-</b> 7759	Z 34 0 🗆 🗆	nday) If Under 1 Year If Under 24 Hrs Months Days Hours Min					
and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	10d. Inside City L				
death with the Maryland ims 23a or 28a-f show	ţ	MD Anne Ar	undel Davić	lsonville	1 <b>∑</b>  Yes 2[				
or 282	irec	10e. Street and Number		10f. Zip Code	10g. Citizen of What Country?				
23a c	je Je	2729 Patuxent Riv	ver Road	21035	US				
or ite	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- tro Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White				
"natural",	Completed	15. Decedent's Edu		Decedent's Usual Occupation	16b. Kind of Business/Industry				
within / iene. <b>than "r</b>	nple	(Specify only highest grad Elementary/Secondary (0-12)		Give kind of work done during most of wo life. DO NOT use retired)	rking				
e riled within al Hygiene. I other than " vent, Inc.Me	Sol	8		Pressman	Judd & Detweiler I				
s i and z should be filed within if Health and Mental Hygiene. If Health z Z is marked other than other traumatic event, the Mental in the Men	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maiden Surname)				
z snould be r and Mental   is marked of aumatic eve	ျ	Richard Kemper Sr			ee Henshaw				
h and h and ris m raum		19a. Informant's Name/Relationship (7)			tural Route Number, City or Town, State, Zip Code)				
Health Health em 27 i		Barbara Harringto		Patuxent River Rd	. Davidsonville, MD 21035				
or of a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State 20b. Place of L cemetery,	Disposition (Name of crematory or other place)	Date 20c. Location - City or Town, State				
permit, rag Department Important: I any Injury o	١,	4 □ Donation 5 □ Other (Specify)			7/2009 Brentwood, MD				
permit, rages I an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licens			ort Lincoln Funeral Home D. Brentwood, Md. 20722				
hysician /Medical the private transit the private transit the private transit the private transit the private transit the private transit tran	disease or condition resulting in death)  a. Coronary Artery Disease Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
physicia the bur	edical		d						
by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year				
signed d be dei	by	Part II. Other significant conditions con	ntributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death				
shoul	lete								
rtificate has tor, page 2	e Completed	25. Was case referred to medical			24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 24b. Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 ☒ No 1 □ Yes 2 □ No				
this certificaral director, p	<u> </u>	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Outp	Othori	ath (Check only one)				
er thi	n: To	27, Manner of Death	28a. Date of Injury 28b. Tin	ne of 28c, Injury at	Home 5₺ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
s after death. Il Director: After ad in by the funer	Certification:	1 X Natural 2 Accident 3 Suicide 4 Homicide  1 Pending investigation 6 Could not be determined	(Month, Day, Year) Inju  28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
within 24 hours after <b>To the Funeral Dire</b> completely filled in b	edical C	29a. Certifier (Check only one)  1 ☑ Certifying Physical Examination (Check only one)	sician: To the best of my knowledge, oner: On the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occurred to the contract of	e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)				
within <b>To th</b> comp	Me	29b. Signature and title of certifier	82Kll m	29c. License number D29193	29d. Date signed (Month, Day, Year)  October 5, 2009				
	ı F	30. Name and address of person who co	mpleted cause of death (Item 23a) (Ty		JECOBEL 3, 2009				
, 6		oc. Italie and address of person who co	inpleted cause of death (item 23a) (1)	pe, mill)					

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		•	rtificate of		Re	g. No. 2. 0. 1. 9	33424			
П	Physici	an	Decedent's Name (First, Middle, Last	* 11				2. Date of Death Month	Day Year	3. Time of Death			
-	/Medio	cal	4a. Facility Name (If not institution, give	SmcHu e street and number)		4h City Town o	r Location of Deatl	10-3-2	4c. County of Deat	4:45 PM <sup>M</sup>			
and .	Examir	ier	GENESIS LAY HILL (			SILVER S		MONTGOME					
	Funeral Director		223-20-1983	ex TM 2□ F  7. Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11-20-1	Year) 9. Birti Co. 924 WASH	nplace (State or Foreign untry) DC			
	Maryland -f show	tor	Usual Residence of Decedent		Town or Loc OLN					10d. Inside City Limits 1			
	n with the 13a or 28a st be notif	<b>Funeral Director</b>	10e. Street and Number 4603 WINDING STO	NE CIRCLE		10f. Zip Code 2083	2		g. Citizen of What Co U.S.A.	untry?			
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'lle Midical Evarines rust be notified at once.	ò	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 🎇 No Specify:			14. Race - Ame Black, White Specify: BL	, etc.			
215-0		Completed	15. Decedent's Ed (Specify only highest grader) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give life. L	DO NOT use retire	during most of wor	king	6b. Kind of Business/I	SPACE			
d 21	filed wil Hygien other th	e Con	Flamentary/Secondary (0-12)  17. Father's Name (First, Middle, Last)		SECUR	<u> </u>	18. Mother's Nan	ne (First, Middle, M	SURVEILLAN	CE SYSTEM			
ylan	Suld be Mental arked of atic ev	To Be	CLARANCE SMITH		,	· · · · · · · · · · · · · · · · · · ·	HELEN	WATSON					
, Mar	and 2 shu ealth and n 27 is m		19a. Informant's Name/Relationship (7 JACQUELINE S. TUR	NER-DAUGHTER	4603	WINDING	STONE CI	ral Route Number, RCLE OLN	City or Town, State, Z EY, MD 208	32			
Baltimore, Maryland 21215-0036	Pages 1 ment of H ant: If iter lury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	hemoval nom State	VET. C	sition <i>(Name of</i> natory or other place EMETERY	10-14	4-2009 C	DC. Location - City or THELTENHAM,	MD			
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licens	Finckne			ss of Facility P		PANGLER F. SH., DC 20				
ind,	Physician		23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. CORONARY ARTERY DISEASE										
	/Medical Examiner		resulting in death)	Due to (or as a consequence CERERBRU	ence of):								
	uted 1 insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque									
68760,	ficate be executed physician and s the burial-transit		that initiated events ' resulting in death) Last	Due to (or as a conseque	ence of):	_							
687	ertificate ing phys e as the	Medical		d									
O. Box	attend for us	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1  □ Live birth 2  □ Fetal ( 4  □ Pregnant at time of de 9  □ Unknown	death 3	Ectopic pregnand Other (specify)	у		23d. Date of deli Month	very Day Year			
JS, P.	res that the de signed by the be detached	by	Part II. Other significant conditions co	ntributing to death but not result	f.	derlying cause giv	en in Part I.		acco use contribute to	A			
200	w requires s been sign should be	leted	Prostate	Margna		NEOFK!	711 6	1 ∐ Yes 24a. Was an	s 2 No 3 Pro	obably 4% Unknown topsy findings available			
tal Re	sician: The law certificate has rector, page 2 9	Completed	25. Was case referred to medical					autopsy perform 1 □Yes 2	ed? prior to death?  ∏No 1 □ Yes	ompletion of cause of 2 □ No			
$\equiv$	ysicia is cert directo	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	t 3 □ DOA Oth		th (Check only one	) nce 6 □Other <i>(Spec</i>	Nfv)			
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; p	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injur Wor		28d. Describe hov		муу			
Ž O	ital or Attendii rs after death. al Director: A led in by the fu	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,			
	he Hospi in 24 hou he Funer ipletely fil	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of my know Iner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the tirestigation, in my o	me, date and place pinion, death occu	e, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)			
	With To 1	Σ	29b. Signature and title of certifier	0		29c. License number 29d. Date signed (Month, Day, Yea							
			30. Name and address of person who o	ompleted cause of death (Item:	23a) (Type. F	Print)	D 6530		(0 3 00	1			
R	5		F. AJMAL, M. D. 1	3917 COACHMAN	DRIVE		OWN, MD	20874					
	Stat Registra		OCT 0 & 2009	32. Registrar's Signatu	Ire Carl								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Year LEONARD SHOATS JR. 29 2009 SEPTEMBER <u>12:2</u>8P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 579-78-8724 Director WASHINGTON, DC 50 FEB. 11 1959 Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 23a or 28a-f show ust be notified at 10d. Inside City Limits Director DC WASHINGTON Y∏Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA nit. Pages 1 and 2 should be filed within 72 hours after death variment of Health and Mental Hygiene.

vrant: If item 27 Is marked other than "natural", or items 23.

in ury or other traumatic event, the Wedical Examiner: by Funeral 115 WAYNE PLACE S.E. # 101 20019 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 **BLACK** 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9TH SCHOOL BUS DRIVER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENNIE J. CRANK LEONARD SHOATS SR. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA BARTON/SISTER 7914 POLK STREET GLENARDEN, MARYLAND 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 10-6-2009 RIVERDALE, MARYLAND permit.
Departnimeta
any init Signature of Funeral Service Vicensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 6 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ey mohia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death Day 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate performed' 1 □ Yes 1 ☐ Yes 2 No 2 HV Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ၉ 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of Certification: After 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending death. n 24 hours after death.

le Funeral Director: A pletely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31

**6** 2009

31. Date filed (Month, Day,

Universe

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32. Registrar's Signature

			1 - For State Registrar	State of Marylan		rtment of He tificate of L		ental Hygier Reg. I	21114	33425
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  Team et en en en en en en en en en en en en en		Shi	4b. City, Town, or		100	Day Year 4 2009 4c. County of Death Garret	3. Time of Death
	Funeral Director		5. Social Security Number 6/ Sex		last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yes July 11		lace (State or Foreign try)
	he Maryland Ba-f show	Director	10a. State 10b. County  WV Prestor		y, Town or Loc	Alta				0d. Inside City Limits 1 🌠 Yes 2 🗌 No
	th with the 23a or 2		10e. Street and Number 527 W. State S	treet		10f. Zip Code 26764	4		Citizen of What Coun U . S .	try?
036	ours after dea ral', or Itams Examinar m	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Morried	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 To No If Yes, Give Year or Dates:	If	/as Decedent of His Yes, specify Cuban ☐ Yes 2 1 No	spanic Origin? (Spec h, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itams 23e or 28e-f show event, the Modical Exercifier cust by multified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation completed) College (1-4or 5+)	(Give k life. D	ent's Usual Occupation of work done du O NOT use retired)	tion uring most of working	g	Kind of Business/Inc	.,
Maryland 2	Mental Mental arkad c	To Be C	17. Father's Name (First, Middle, Last) Wade M. Frankh					(First, Middle, Maid L. Elias	<sub>en Sumame)</sub> on Frank	houser
	s 1 and 2 sho of Health and itam 27 is m other traum		James R. Shilli	•					vorTown, State, Zip Alta, WV	
Baltimore,	ot is is		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crem	ition (Name of atory or other place ematory			Location - City or To rgantown	
Balt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service License	Speece	22. A 1	Name and Address rthur H 05 High				WV 26764
	Physician and // // // // // // // // // // // // //	dical Examiner	23a. Part1. Enter the disease, or complic shock, ok heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):	r the mode of dying,	, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
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cords, P.	w requires that the debeen signed by the should be detached	by P	Part II. Other significant conditions cont	ributing to death but not resu	ilting in the und	derlying cause giver	n in Part I.	23e. Did tobacco	use contribute to th	
ı Hec	The larate has page 2	Completed						24a. Was an autopsy performed?	prior to con death?	osy findings available apletion of cause of 2 No
on or vital	ξή isin	lon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No						6 Other (Specify	)
DIVISION	ital or Attandrs after death ral Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stree )		es 2 □ No 28	if. Location (Street and City or Town, Sta	and Number or Rural te)	Route Number,
	To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Medical	29a. Certifier 12 Certifying Physic Check only 2 Medical Exemina Medical Exemina 29b. Signature and title of certifier	er: On the best of my knower: On the basis of examination and manner stated.	vledge, death of ion and/or inve	occurred at the time estigation, in my opin	nion, death occurred	at the time, date a	s) and manner as stand place, and due to place and (Month, L	the cause(s)
		10	30. Name and address of person who con	npleted cause of death (Item	23a) (Typa-e	172	6015 M	terec	01051	09 (Clark
	Sta Registr		31. Date filed (Month, Day, Year)  OCT -5 200	32. Registrar's Signati	ure	a dal	10011			71) 7150

			For State AMEND#20a-C,2				artment of F		nd Mer	_	70 70	0.0	1 (
	\$k		Decedent's Name (First, Middle, 1)		4/UJ,II	.14,140001	incate of	Death	2.	Date of Deat	eg. No. 🤈 🗍		3. Time of Death
F	hysici /Medio		Mildred Hele	n To	or				00	Month ctober	1, 2009	Year 9	11:10 P <sup>M</sup>
7 1	Examin	- 4	4a. Facility Name (If not institution, g	give street and number	r)		4b. City, Town, o		Death		4c. County	of Death	
_	New or statement	7	Aspenwood Senior  5. Social Security Number 6			lty last birthday)	Silver	•		Date of Birth	Mont		J
	uneral rector		050-24-5850	1 M 2 M F	88	Yrs.	Months Days	Hours	Min.	(Month, Day, Oct. 4,	<sup>Year)</sup> 1920	Cour	lace (State or Foreign try) (inia
pu	>		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	cotion						0.4 1
Aaryla	shoved at	ō	MD Montgo	.m.e.r.;									0d. Inside City Limits 1
the A	notifi	Director	10e. Street and Number	mery	51.	lver S <sub>I</sub>	10f. Zip Code			10	Og. Citizen of W	/hat Cour	itry?
th with	23a o		14400 Homecrest	Road Al3			2090	)6			U.S.A.		
er dea	lems er mu	Funeral	11. Marital Status	12. Was Deceden	2		Was Decedent of H	Hispanic Origi pan, Mexican,	in? (Specify Puerto Ric	y Yes or No-	14. Race	- Americ	an Indian, etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TXYes 2 If Yes, Give Year or Dates:		+	1 □ Yes 2 □ <b>x</b> No				Specify.		ite
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene.	atura Ical E	Completed by	15. Decedent's	Education		16a. Dece	dent's Usual Occup			-7	16b. Kind of Bu		
ithin 7	an "r Med	nple	(Specify only highest (Specify only highest	College (1-4or	r 5+)	life. I	kind of work done DO NOT use retire	during most ( d)	of working				
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<u>a</u> e ⊒	c eve	o Be		old				_			laiden Surnam	e)	
laryla 2 should and Men	marl mati	P	Harry B. Go 19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	Rut and Number		loffer Route Number,	City or Town,	State, Zip	Code)
	l item 27 Is marked r other traumatic e		Robert Sperlin	ıg/ Lawyer		9716	Shadow 0	ak Dri	lve, G	Gaither	sburg	MD 2	0886
			20a. Method of Disposition  13 Burial 2   ☐ Cremation 3	FRamoval from State	_ Atla	Place of Dispo	sition (Name of	ce) C	ct II,	2009	len Burn	City or To	wn, State
Baltimore, permit. Pages 1 ar Department of Hea	Important; I any injury o once.	t	4 □ Donation 5 □ Other (Spe	cify)	Ari		Nat: Ce		1/17/		rlingto		_
Balt permit. Departr	any i		21. Signature of Funeral Se Ace Lice Ed	Sagel M009	10	3	reden Mo LGIST Ave. 70 Rocky	Turix S TITE I	ervice ver Sp	PA ring, M	oldberg 1 20910	208	INC.
	79		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each	ed the deat line.	h. Do not ent	er the mode of dyi	ng, such as c	ardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
	ician edical		Immediate Cause (Final disease or condition resulting in death)				Cardiova	scular	Dise	ease			Onset and Death
	miner			Due to (or as	s a conseq	uence of):							
	. iš	Jer	Sequentially list conditions, on the conditions, cause. Enter Underlying Cause (Disease or injury	b. — Due to (or a	s a conse	uence of):							
8760, Cate be executed	nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760, ate be ex	sician and burial-trans	E	resulting in death) Last	Due to (or as	s a conseq	uence of):							
587 ficate	the h	dical		d							<u> </u>		
BOX (  Bath certi	attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e pf pregna						23d. Date	e of delive	rv
o deatl	ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnanc Other (specify) _	У			Mor	nth	Day Year
hat the	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions		hut not roo	ulting in the		and to Book t		00+ Did t-b			
Hecords, P.O. Box 6  The law requires that the death certific	been signed by the should be detached	d by	Hypertensio		out not lest	ulding in the th	idenying cause giv	en in Pan i.					e cause of death? ably 4 XUnknown
	shoul	lete							_	24a. Was ar			psy findings available
The la	page 2 (	Completed							_	autops: perform	p ned? d	rior to cor eath?	npletion of cause of
VITAI ician: ]	certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place o	of Death (C	1□ Yes 2 Check only one		L 162	2010
		္	1 ☐ Yes 2 ☐ No			ER/Outpatien		4 LI Nurs			nce 6 🖸 Othe		Assisted Living
ding	Affer	i i i	27. Manner of Death  1 XNatural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inj (Month, Da		28b. Time of Injury	Wor	ryat rk? ∣Yes 2.∐No		I. Describe ho	w injury occurre	ed	
UIVISION I or Attending after death.	ector: by the	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of in	njury - At ho	me, farm, str	eet, factory, office	103 2		Location (Str	eet and Numbe	er or Rura	l Route Number,
talor A	neral Director: After this filled in by the funeral di	Certification:	4 ☐ Homicide . determine	building, e	etc. (Specify	y)				City or Town	, State)		
To the Hospital o	completely fill	Medical	29a. Certifier 1 ♣ Certifying I  (Check only one) 2 ☐ Medical Ex	Physician: To the best aminer: On the basis and manner s	of examina	wledge, death tion and/or in	n occurred at the ti vestigation, in my o	me, date and opinion, death	place, and h occurred	due to the ca at the time, da	use(s) and ma ate and place, a	nner as st	ated. the cause(s)
To th	dwoo	Me	29b. Signature and title of certifier	1			29c. Licens	e number		29	d. Date signed	(Month,	Day, Year)
10			1 ( lung	aysus			D3979	93		0	ctober	4, 20	009
			30. Name and address of person wh		,	, , , , ,	,						
	Sta	6	Christopher Mays 31. Date filed (Month, Dav. Year)	MD 18111	Prin trar's Signa	ce Phi	lip Driv	e. 01n	ey, M	D 2083	2		
F	Registr	ar	Christopher Mays 31. Date filed (Month, Day, Year)  OCT 05 20	109 Centus	JA 0	. par	Ked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20b&c Per FR G896 10/22/09 Jh of Health and Mental Hygiene

			1 - State Registrar	State of Ma	ryianu		tificate of		vientai Hy	Reg. No.	19	33423	
	Physici		1. Decedent's Name (First, Middle, La THEODORE	JOSEPH	TH	OMAS			2. Date of De Month SEPTEMI	Day BER 30 20	Year	3. Time of Death 7:47 P M	
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	or Location of Death		4c. County			
_			PRINCE GEORGE'S				CHEVE		T a a i (a)			ORGE'S	
	Funeral Director		5. Social Security Number 577-62-9428 Usual Residence of Decedent	1KDM 2∏F	Months Days Hours Min. (Mo				8. Date of Bir (Month, Da AUG. 2	ay, Year)	9. Birthp Coun VASHI	olace (State or Foreign htry) NGTON, DC	
	yland how		10a. State 10b. County		10c. City, T	own or Loc	ation				1	0d. Inside City Limits	
	e Mar Ba-f s	Director	MD PRINCE (	GEORGE'S	LA	NDOVE	R					1 <b>X</b> 1Yes 2 ☐ No	
	with th		10e. Street and Number	*****			10f. Zip Code			10g. Citizen of V	Vhat Coun	ntry?	
	ns 23	Funeral	1912 OREGON AVEN	12. Was Decedent Ev	ver in U.S.	13. V	20785		pecify Yes or No	USA 14. Bac	e - Americ	an Indian,	
980	be filed within 72 hours after death with the Maryland ital Hygiene. so other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at	þ	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:			Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		k, White, o	etc.	
21215-0036	72 ho 'natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give kind of work done during most of working					16b. Kind of Bu	siness/Ind	dustry	
121	filed within 72 Hygiene. sther than "nai	Jupo	Elementary/Secondary (0-12)	College (1-4or 5+) 4 YRS	)	PHOTOGRAPHER				COVEDA	COMEDINATION		
2	filed Hygi other ent, U	Be Cc	17. Father's Name (First, Middle, Last			rn	UIUGKAPU	18. Mother's Nam	e (First, Middle	GOVERN , Maiden Surnam			
/lar	should be filed withir and Mental Hygiene.  marked other than umatic event, It all	To B	ARTHUR THOMAS					MARY	ROBIN	ISON			
Maryland	S 8 8 8		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	ber, City or Town, State, Zip Code)			
	s 1 and 2 of Health item 27 i		JANICE M. THOMAS/WIFE  20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  1 AROMONY CEMETERY  1912 OREGON AVENUE LANDOVER MARYLAN  20c. Location Chelten  1AROMONY CEMETERY  10-9-2009  LANDOVI									85	
J O	Pages nent of int: if its iry or o												
Baitimore,	permit. Pages Department of Important: If It any injury or o	1	21. Sunat re of Juneral Service Lice		12110		Name and Addre			INKINS FU			
n	89 = 88	9	Man					DOVER ROA			LAND	20785	
	Physician	1	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line			er the mode of dyi	ng, such as cardiac	or respiratory a	urrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a									
			Sequentially list conditions,	b Due to (or as a	consequen	ce of):					-		
	cuted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6		.,.							
Š,	tificate be executed g physician and as the burial-transit	Ë	resulting in death) Last	Due to (or as a	consequen	ce of):							
<b>68/6</b> 0,	physic the b	edical		d									
	± 5, 4		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d Dat	e of delive	erv	
	the death cery the attendir	hysician/N	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown			Ectopic pregnand Other (specify) _	cy .		Mo		Day Year	
ν, Τ	de de	by P	Part II. Other significant conditions	contributing to death but	not resultin	g in the un	derlying cause giv	en in Part I.	23e. Did 1	obacco use conti	ribute to th	ne cause of death?	
Hecords	equire				<del></del>				10	Yes 2 □ No	3☐ Prob	ably 4∑ Unknown	
ပ္	has be	Completed				-			24a. Was auto	psy g	prior to con	psy findings available mpletion of cause of	
	n: The ficate h		<u></u>						perfo 1 □ Yes		leath? □Yes	2No	
VITAI	Physician: r this certific ral director,	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	- MT ED	Outpotions	3 □ DOA Oth	26. Place of Deat		,			
101	ig Phy ter this neral c	ت. ح	27. Manner of Death	28a. Date of Injury (Month, Day,	28	b. Time of Injury	28c. Inju	ry at		dence 6 Other		y)	
Sion	Attending it death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	1	rear)	підагу		Yes 2 □No					
Š	safter de	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc.	/ - At home (Specify)	, farm, stre	et, factory, office		28f. Location ( City or To	Street and Number wn, State)	er or Rura	l Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	Medical (	29a. Certifier (Check only one)	nysician: To the best of niner: On the basis of e and manner state	examination	dge, death and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and ma date and place, a	anner as s and due to	stated. the cause(s)	
	To th Comp	Me	29b. Signature and title of certifier	0	tusi.	[	29c. Licens	se number		29d. Date signed	Month,	Day, Year)	
			) galney	when i,	(31	cim	D5:	3590		OCTOBER	6,	2009	
1	2/0		30. Name and address of person who SYDNEY DY M.D					ERTON MAD	VI.AND 2	0705			
1	Stat	e	31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	-	UNIIV.	LICHTON		0,00			
	Registra		OCT 0 a 2009 Z	Ener D.	Mar	Kel							

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alvin David WEINSTEIN October 2009 10:47 A <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Montgomery Good Samaritan Assisted Living 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours (Month, Day, 84 578-20-9212 Director Washington, DC Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🗆 Yes 2 况 No Mary land Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 20901 1105 Playford Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedo... Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 Maryland 21215-0036 1 ☐ Yes 2 X ☐ No Specify: Specify: white "natural", 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates. WW-II the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Owner/Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nettie Yockelson ၉ Alexander Weinstein <sup>19a.</sup> Informant's Name/Relationship *(Type, Print)* Selma Weinstein, Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Playford Lane, Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lebanon Cemetery 10-05-09 Adelphi, MD Mt. 21. Sign there of Funeral Strvice Licensee 22. Name and Address of Facility Torchinsky Herrew Funeral Home M01008 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Day'S Between Immediate Cause (Final Ph sician/ disease or condition resulting in death) Acute Intracerebral Hemorrhage Medical Due to (or as a consequence of): Examiner Swauentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the initial prices of the stranger of the stran use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy į in the past 12 months? Pregnant at time of death Month 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown sate has been signed bage 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other:  $_4$   $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify) ASS is ted မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Living 5 Pending 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the pags of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) October 2, 2009 D 098321 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Rosenbaum, M.D., 3720 Farragut Ave., Kensington, MD 20895

State

Registrar

31. Date filed (Month, Day, Year)

arked

2. Registrar's Signature

			1 - For State Registrar  1. Decedent's Name (First,		Jale UI		-	rtificate of	Health and N Death		Reg. No.	3, Time of Death	
	Physici /Medi			phine	Walsh						per 30, 200		
Ü	Examir	ner	4a. Facility Name (If not ins Rockville N			er)			or Location of Death ckville		4c. County of Death  Montgomery		
	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	h a Ri	rthplace (State or Foreign ountry)			
	Director		091-07-4645 Usual Residence of Decede		2 <b>ॉ</b> F	92	Yrs.	Wioritins Days	Hours Min.	Sept. 2	9, 1917 й	ew York	
	iryland i <b>how</b> fat	_	10a. State 10b. C			10c. Cit	y, Town or Lo	cation		-		10d. Inside City Limits	
	the Ma 28a-f s lotified	ecto	Maryland N  10e. Street and Number	lontgome	ry		Ro	10f. Zip Code			1 Yes 2 No		
	3a or	a Dir	11100 Wayo	roft Wa	У		20852				10g. Citizen of What Country?  USA		
٥	illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	11. Marital Status 1 Never Married 2		Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give	es?		Was Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto	pecify Yes or No Pican, etc.)		te, etc.	
200	hours tural", al Exal	d by	3 X Widowed 4 □ Div		Year or Date	es:					Specify: Wh		
Maryland 21215-0036	within 72 ene. than "nat ne Medica	Completed by		cedent's Educat highest grade c -12)		or 5+)	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire	during most of work	king	16b. Kind of Business Clerical	s/Industry	
ק ק	other other	Be Co	17. Father's Name (First, M	iddle, Last)				recary	18. Mother's Nam	e (First, Middle,	Maiden Surname)		
ylar	ould be Menta arked arked	다 B	Joseph Casey					Margaret Barrett					
, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)  Thomas Emmett Walsh, Jr./Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  11100 Waycroft Way, Rockville, MD 20852										
Baltimore,			20a. Method of Disposition 1X Burial 2 □ Crem.		oval from Sta	ate C	emetery, crer	sition (Name of natory or other pla Ieaven Ce	ce) Oc	Date	20c. Location - City of		
altin	mit. Poartme		4 ☐ Donation 5 ☐ Ot 21. Signatur of Funeral Sc	- 2	1	Joan				2009	l Home Inc	ing, Maryland	
n	o a m o	1	Tru	\$ 50	erle	0		oud unive	ersity Bit	7a. W.,	Silver Spr	ing, MD 2090	
		2 1	23a. Part1 Enter the disea shock, or heart failure Immediate Cause (Final	se, or complicate. List only one				_	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death	
	hysician /Medical		disease or condition resulting in death)	a		as a consequ		Disease					
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	Due to /or	as a consequ	uonoo of):						
,	ured d ansit	Examiner	Cause (Disease or injury that initiated events	3	Due to (or	as a consequ	uerice oi).						
, 0	Incate be executed physician and as the burial-transit	cal Exa	resulting in death) Last  Due to (or as a consequence of):										
28	runcare ng phys as the	Nedic	IE EGMALG.	d									
). Box	The raw requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 Yes 2 No	TIL F		n 2□Feta tattime of d	Ideath 3□	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year	
7 O	res triat the designed by the s		9 ☐ Unknown  Part II. Other significant co	nditions contril			ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	bbacco use contribute t	to the cause of death?	
rds	v requires been sign should be	ed by	Dementia							101	∕es 2□No 3□F	Probably 4 🛱 Unknown	
Vital Records,	hasbee e 2 sho	Completed								24a. Was	sy prior to	utopsy findings available completion of cause of	
			25. Was case referred to m	adical						1□ Yes		s 2□No	
	rthis certificate has ral director, page 2	To Be	examiner? 1 ☐ Yes 2 ☒ No		pital: 1 ∐ Inp	atient 2□	ER/Outpatien	t 3 DOA Oth	26. Place of Deather: 45 Nursing Ho		ne dence 6 □Other (Spi	ecify)	
0 00	Affe			ending	28a. Date of (Month,	njury Day Year)	28b. Time of Injury	Wo	ry at rk?		now injury occurred		
DIVISION OF	ir Alteriter ter deat irector:	Certification:	2 Accident investigation 3 Suicide 4 Homicide   M   1 Yes 2 No   28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   28f. Location (Street and Number or Rural Route Number, City or Town, State)									Rural Route Number,	
	within 24 hours af  To the Funeral D  completely filled in	Medical Ce	29a. Certifier 1X Ce (Check only one) 2  Me	rtifying Physic dical Examine	an: To the be On the basi and manne	s of examina	wledge, death	occurred at the ti	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)	
	within To the	Me	29b. Signature and title of c	ertifier		MD		29c. License number 29d. D64624			29d. Date signed <i>(Mon</i>	th, Day, Year) 2, 2009	
• 22.	₹				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sandeep Sharma, MD 743 Summer Walk Drive, Gaithersburg, MD 20878								

State Registrar

OCT 05 2009

31. Date filed (Month, Day, Year)

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Of IVIA	ryiand / Depa <i>Cer</i>	rtificate of L			erie g. No, 7 A A A	221.21
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	_	Runetta Veronica Walke:	r				er 28, 2009	8:25 P M
and the same	Examin		4a. Facility Name (If not institution, give street and number)	"		Location of Death		4c. County of Death	
and the			3005 S. Leisure World Blvd.  5. Social Security Number 6. Sex 7. Age		Silver	Spring If Under 24 Hrs.	8 Date of Birth	Montgomery	place (State or Foreign
Ü	Funeral Director		5. Social Security Number   6. Sex   7. Age   5.79 − 40 − 3.322   1 □ M 2 ⊠ F   7. Age   7. Usual Residence of Decedent	(In yrs. last birthday).	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 5,	Year) Cou 1930 Wash	ington, DC
	land ow		10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Montgomery	Silver S	pring				1 ☐ Yes 2 🔀 No
	or 28	)ire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?
	ath wi	<u>la</u>	3005 S. Leisure World Blvd.			20906		United S	
36	within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 23a-f show	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	Was Decedent of H fYes, specify Cuba I □Yes 2⊠ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: Afr:	etc.
Maryland 21215-0036	2 hou	ted	15. Decedent's Education	16a. Deced	dent's Usual Occup	ation	ing 1	6b. Kind of Business/Ir	
21		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-	+) (Give	DO NOT use retired	during most of work f)	ing		
21	e filed within al Hygiene. I other than ' vent, In w	Cor	12	Admir	nistrativ	e Assista 18. Mother's Nam		Walter	Reed
anc	0 = 0 0	Be	17. Father's Name (First, Middle, Last)					_	
ry	s 1 and 2 should be if Health and Menta item 27 is marked other traumatic ev	ᅀ	Johnny Euell  19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	na Address (Street	Cathering  and Number or Rui		Jenkins City or Town, State, Z	ip Code) 20006
N N	nd 2 salth ar 27 is r trau		Keith R. Brown/Son	1					Spring, MD
re,	of Health of Health item 27 i		20a. Method of Disposition	20b. Place of Disposemetery, crem				20c. Location - City or T	
E	Pages ment of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Gate of H		10/6	/09 s	ilver Spri	ng, Maryland
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Fune al Service Licensee			ss of Facility Sin	ple Trib	oute	
_	207 2 2 2		· Log					.11e, MD 20	
П			23a. Part1. Enter the disease, or complications that caused shock, or beart failure. List only one cause on each lin	the death. Do not ent- ie.	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
all long	Physician		resulting in death)	ry Fibrosis	3				
all!	/Medical Examiner		Due to (or as a	a consequence of):	D1	D:	_		
		ier		Obstructiva consequence of):	e Pulmon	ary Disea	ıse		
B	outed Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						
Ó	e exerian ar	Exa		a consequence of):					
68760,	tificate be executed g physician and as the burial-transit	ledical	d						
	E 50 4	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy				OOM Date of doll	
Вох	death cert e attending d for use a	Physician/N	in the past 12 months?	2 Fetal death 3	Ectopic pregnanc	ry		23d. Date of deli Month	Day Year
0	0 0 0	ıysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown						
о, С.	requires that the been signed by th hould be detache	by Pl	Part II. Other significant conditions contributing to death but	ut not resulting in the un	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ıdş	v require been sig should b	ed b	Carcinoma right upper lobe				1 <b>∑</b> Ye	s 2 No 3 Pr	obably 4 Unknown
Division of Vital Records,	aw as b	Completed					24a. Was ar		topsy findings available completion of cause of
= E	The ate h page	Com					perform	ned?   death?	2 🗷 No
/ita	rystcian: The is certificate director, pag	Be (	25. Was case referred to medical examiner?		044		th (Check only one	9)	
of	ys is	7	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatie  27. Manner of Death 28a. Date of Inju	ent 2 ER/Outpatier		4 LI Nuising A		nce 6 Other (Spec	cify)
no	ding T. After fune	tion	1 X Natural 5 ☐ Pending (Month, Day	y, Year) Injury	Wor	k?  Yes 2∐No	200. Describe no	w injury occurred	
İSİ	or Attending after death. Director: After in by the funer	fica	3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, str				reet and Number or Ru	ral Route Number,
Š		Certification:	4 Homicide determined building, etc	;. (Specify)			City or Town	i, State)	
	To the Hospital or Within 24 hours afte To the Funeral Dit completely filled in	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of the basis of and manner start.	f examination and/or in	h occurred at the ti evestigation, in my	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signed (Monti	n, Day, Year)
	8		Robert H Guard MI	)	DO.	055522		9/29/09	
	U		30. Name and address of person who completed cause of d			<u> </u>		7/49/09	
			Robert H. Gerard, M.D.		st Glen R	oad; Silv	er Sprin	g, MD 2091	0
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 02 2009	ar's Signature	Ked.				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ELOISE S. OCTOBER 2009 3:55A M WILDS 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 16707 DORCHESTER PLACE UPPER MARLBORO PRINCE GEORGE'S 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 1 F Months Days Hours SOUTH CAROLINA 578-60-7613 87 JAN 4 1922 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1376 W STREET N.E. 20018 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: BLACK Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lile. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH DOMESTIC PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BEAU REGARD SCOTT ANNIE LOU BERRY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELOISE A. JONES/DAUGHTER 16707 DORCHESTER PLACE UPPER MARLBORO, MARYLAND 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-8-2009 4 ☐ Donation 5 ☐ Other (Specify) LANDOVER, MARYLAND HARMONY CEMETERY 22. Name and Address of Facility ature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. shock Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER OF THE URETER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

be executed

requires that the death certificate

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician;

hours after death

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic excent

/Medical

10a. State

DC

Director

Funeral

<u>^</u>

Completed

Be

ပ

Examiner burial-tran

Physician/Medical à Completed

Be

IF FEMALE:

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

2 🛱 Accident

4 Homicide

physician the as nse s ģ the detached ģ s been signed be should be deta peen has page 2 certificate Certification: To funeral After

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu Medical

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28a. Date of Injury (Month, Day, Year)

Physician

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

D53590 OCTOBER 6, 2009

1 ☐ Yes 2 🛣 No

24a. Was an

26. Place of Death (Check only one)

autopsy

1 ☐ Yes 2 ☐ No

Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square \text{Cyother}$  (Specify) HOUSE

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

5 ☐ Pending investigation

6 ☐ Could not be

POWER MILL ROAD CALVERTON, MARYLAND 20705 4041

DY M.D. 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician**  $\mathbf{P}^{\mathsf{M}}$ BRENDA WHITE OCTOBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6510 GLEN AVENUE GLENN DALE PRINCE GEORGE"S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Director NOV. SOUTH CAROLINA 1946 248-80-1298 4 Usual Residence of Decedent Show 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, "tw. Medical Examinar must be notified at Director 1 X Yes 2 □ No MD PRINCE GEORGE'S GLENN DALE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 6510 GLEN AVENUE 20769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔯 No Specify BLACK \$ Specify: 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **5YRS** PRINCIPAL PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROY DURRAH JR. DOROTHY L. FERGUSON ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar item 27 TAIJERE WHITE/DAUGHTER 6510 GLEN AVENUE GLENN DALE, MARYLAND 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any injury or ott 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation \_ 5 ☐ Other (Specify) RESURRECTION CEMETERY 10-8-2009 CLINTON, MARYLAND JENKINS FUNERAL HOME f Fuyeral Service Licensee J. B. 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 YRS disease or condition resulting in death) BREAST CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Entry Cause (Disease or injury that initiated events iner Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-tran and resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No o. the 9 Unknown 9 Unknown signed by a σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 1210 certificate 1 ☐ Yes 2 No 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 ∐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🔼 Natural 5 Pending investigation Injury death. 1 ☐Yes 2 ☐ No ours after death.

neral Director; #
filled in by the fu 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the within 2 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name

LEON HWANG M.D

1221 MERCANTILE LANE LARGO, MARYLAND 20774

and address of person who completed cause of death (Item 23a) (Type, Print)

D45880

OCTOBER 5, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Harding Watkins 28, 2009 4:45 September /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Heartland Health Care Nursing Home Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F 225-26-5034 86 Director October 6, 1922 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be retilied at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 ☐Yes 2X No Prince George's Maryland Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Riggs Road 20783 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 □ No
If Yes, Give
Year or Dates: 1943~1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 \$ 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Taxi Driver Self Employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doc Watkins ပ္ Daisy Unav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Mason / Guardian 6420 Allentown Road, Camp Springs, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2009 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Constance Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Ja 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by t should be detach The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐Yes 2 X No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🗖 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Tes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Inpatient this 24 hours after death.

Funeral Director: After the letely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred Division 1 🛛 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the I within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

1 2+1

State Registrar OCT 0 6 2009 Security 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

otovar.

GREGIBELT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Day Year <u>9:</u>25₽M September 30 2009 Marie Wachter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oakland
If Under 1 Year If Under 24 Hrs. Dennett Road Manor

5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1□M 2⊠F Days 23,1915 Director 93 Pennsylvani 213-50-0843 Nov. Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Madical Evan her must be notified at one. 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2 No McHenry MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 889 Rock Lodge Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎦 No \$ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Co-Owner General Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rietsfake Samuel Burns Annie မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 889 Rock Lodge Rd., McHenry, MD 21541 Walter Wachter/ Son 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Deep Creek
Baptist Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/4/2009 Oakland, MD 22. Name and Address of Facility Newman Funeral Homes 21. Signature of Funeral Service Licensee 179 Miller St., Grantsville, MD 21536 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Yein /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) funeral director, page 2 should be detached 1 ☐ Yes 2 🗖 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2X No 3 Probably 4 Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dea...ral Director: Aftr 1 X Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 09 H0064705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 311 N. Fourth St., Oakland, MD 21550 Richard Porter MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar		State of IV	larylan		irtment of t tificate of		Mental Hy	giene Reg. No.		3343
150	Physic	ian	1. Decedent's Name (F	First, Middle, Las	t)					2. Date of De	eath Day	Year	3. Time of Death
	/Medi		Frank B.							Octobe			6:20 A M
	Exami	ner	4a. Facility Name (If no	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. City								County of Death	
			2909 Mont	clair D					ott City			Howard	
	Funeral Director		5. Social Security Number 5. Social Security	22	9X 7. A	ge (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1930	9. Birthp Cour	place (State or Foreign htry) MD
	aryland show	_		Db. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	he M 8a-f otifie	Director	MD	Howard		El	licott						1 ☐Yes 2 X No
	vith t	Ö	10e. Street and Numbe					10f. Zip Code	_			en of What Cour	
	s 23g	a	2909 Mont	clair D				2104				ited Sta	
980	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ∐Yes 2 No		Vas Decedent of Nes, specify Cub ☐ Yes, specify Cub ☐ Yes 2][] No		Specify Yes or No erto Rican, etc.)		14. Race - Americ Black, White, Specify: Whit	etc.	
ŏ	2 hor	ted	,15	. Decedent's Ed	ucation		16a. Deced	ent's Usual Occu	oation			nd of Business/Inc	
21215-0036	within 7 iene. than "n the Medi	Completed	(Specify of Elementary/Secondary	only highest grad	College (1-4or	life, DO NOT			d)	orking		Self Employed	
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Maryland	d 2 should be f th and Mental I 7 Is marked ot traumatic ever	To B	George L.  19a. Informant's Name		B ( 0		1		Maude	R. Bray			
	127 ¥ 7		Frances K	, , ,		ife				Rural Route Numb			
Baltimore,	r it of		20a. Method of Disposit  1 ▼Burial 2 □ C  4 □ Donation 5 □	remation 3 □	Removal from State	, ,	emetery, cren	sition (Name of natory or other pla	i i	Date		cation - City or To	
Ħ			21. Signature of Funera		_			ark Cem.		09–2009		timore,	
Ä	permit. Departr Importa any inji		Shem	Colle	s- with	$\frac{\text{MO104}}{\sim}$	41	<u>12 Old C</u>	olumbia	<u>Pike Ell</u>	icot	e's Fami t City,	ly FH Inc. MD 21043
	Physician		23a. Part1. Enter the d shock, or heart fa Immediate Cause (Fina disease or condition				h. Do not ente	er the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		a. Pneumo Due to (or as	a consequ							
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o.	requires that the death ce een signed by the attendir nould be detached for use	Physician/M	in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnanc Other <i>(specify)</i> _	y			Month	Day Ye <i>a</i> r
S, D	es that gned to be deta	by PI	Part II. Other significar	nt conditions co	ntributing to death t	out not resu	ulting in the un	derlying cause giv	en in Part I.	23e. Did t	obacco us	se contribute to the	ne cause of death?
Vital Records	w require	eted		-						1 🗆 '	Yes 2	No 3□ Prob	ably 4 □Unknown
Rec	has has	Completed									osy ormed?	prior to cor death?	psy findings available npletion of cause of
ta	(G TT	Bec	25. Was case referred to	to medical					26 Place of Do	1  Yes eath (Check only o	2 <b>½</b> No	1 🗆 Yes	2 □ No
>	ysici is ce direc	To B	examiner? 1 ☐ Yes 2☑ No		Hospital: 1 ☐ Inpati	ent 2 🗍	ER/Outpatient	3□ DOA Oth	0.51	Home 52 Resi		□Other (Specifi	d
101	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death		28a. Date of Inju	ury	28b. Time of	28c. Inju		28d. Describe I			//
Ö	ath. art. Af	atio	1 Natural 5 2 ☐ Accident	Pending investigation	(WORLI, DE	iy rear)	Injury		k? Yes 2∐No				
	al or Atte after de I Directo d in by th	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of in building, e	ury - At ho tc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tox		Number or Rura	I Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2	Certifying Phy Medical Exami	sician: To the best ner: On the basis of and manner st	of examinat	wledge, death tion and/or inv	occurred at the tile estigation, in my o	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) a	and manner as si place, and due to	tated.  the cause(s)
	To the l within 2 To the l complet	M	29b. Signature and title	of certifier	•			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
			1 R	Rin	- no el	-		D19	478		10	/05/09	
13	-		30. Name and address								•		
			Roy Brower	Johns H	lopkins H	ospit	al 600		olfe St.	Baltimo	re 21	L287	
	Sta	te	31. Date filed (Month, D	T 05 20	32 Aegisti	ar's Signat	ture L	.V.I					

DHMH 17 Rev 1/2001

		Pleas	e Type or Print in Black	k Indelible Ink. Ensure	All Copies A	re Legible.	
		For	State of Maryland / [	Department of Health and	Mental Hygie	ene	
		State Registrar		Certificate of Death	Reg	g. No.	33437
Physici	an	Decedent's Name (First, Middle,	AII	0	Date of Death     Month	Day Year	3. Time of Death
/Media	cai	rancine		ze	10	14 2009	5:25 "
Examir	ner	4a. Facility Name (If not institution,	11 . 1 .	4b. City, Town, or Location of Dea	atn	4c. County of Deat	
Funeral		5. Social Security Number 6	re Hospital 3. Sex 7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24 Hi		9. Biri	thplace (State or Foreign
Director		218-58-9082	1□ M 2 <b>X</b> F 56	Yrs. Months Days Hours Mil	n. (Month, Day, )	952 N	Carolina
w w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
Maryia f sho	0	1.2		edale			1 No 2 No
r 28a-	rec	10e. Street and Number	imore Kas	10f. Zip Code	100	g. Citizen of What Co	
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ems ems	ner	11. Marital Status	12. Was Decedent Eller in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Ame Black, White	
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hour fural	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	Decedent's Usual Occupation	16	Sb. Kind of Business/	racic
nin 72 n "na Nedic	Completed	(Specify only highest	grade completed)	(Give kind of work done during most of w life, DO NOT use retired)		Toho H	PKINS
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be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	.st)	18. Mother's Na	ame (First, Middle, Ma	iden Surname)	7
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permit. Pages Department of Important: If it any Injury or o		21. Signature of Superal Service Lie		22. Name and Address of Faglity	240470	SITIMO	e ML
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ath ce	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of del	•
the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month	Day Year
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hysic this ce Il direc	၉	examiner? 1 ✓ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Out	Othor	Home 5 ☐ Residence	ce 6 Other (Spe-	cify)
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after after Direct	Certification:	4 ☐ Homicide determine	28e. Place of Injury - At home, farr building, etc. (Specify)	in, street, factory, office	City or Town, S	et and Number or Ru State)	iral Houte Number,
ospita hours ineral ly fille		29a, Certifier 1 Certifying I	Physician: To the best of my knowledge,	death occurred at the time, date and place	ce, and due to the cau	se(s) and manner as	s stated.
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the laws.	Medical	Check only 2 Medical Ex	aminer: On the basis of examination and	f/or investigation, in my opinion, death occ	curred at the time, date	e and place, and due	to the cause(s)
5 th 5 th	Σ	29b. Signature and title of tertifier	Thurs	29c. License number	29d.	. Date signed (Month	n, Day, Year)
	-			DO0 2871	7	10/15/0	2009
10		30. Name and address of person wh	and manner stated.  O completed cause of death (Item 23a) (Ter M.D. 9000 France 32. Redistrar's Signature	Type, Print)	1.11.	- 01 - 1	1 0.222
Stat	e_	Stephen Seling, 31. Date filed (Month, Day, Year)	32. Resistrar's Signature	Kun Square Drive	partimore	z, Marylan	no 21231
Registra		OCT 20	2009 Senera S.	farde!			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Day /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c/County of Death Bal Samanka hmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Year 5. Social Security Number 218-58-388 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Evarranar must be notified at Director 1 Yes 2 No hmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 □Yes 2 No Black ģ Specify: Specify: 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Ma Elementary/Secondary (0-12) Callege (1-4or 5+) Lyears pervisor Femer's Name (First, Middle, Last) Be trnethea lames ပ 19a. Informant's Name/Relationship (Type. Pri Rural Route Number, City or Town, State, Zip Code) s (Street and Number of Baltimore, MD 21214 Genevieve 20a. Method of Disposition
1 ☐ Burial 2 Cremation 20c. Location - City or Town, State 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebral **Physician** hemor/hag disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be execut Kension burial-tra Box 68760% Due to (or as a consequence of): attending physician Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. the detached ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Physician: The certificate 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 1 Yes 2 √No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. after death 2 Accident investigation 1 ☐ Yes 2 □ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide e Funeral I 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blud

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** M rown 1Dber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, B. Birthplace (State or Foreign **Funeral** Months Days Min 1 □ M 2 🕱 F Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show notified at 1 Yes 2 No Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩Widowed 4 □ Divorced Specify: [ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Nental Hygiene. Important: If item 27 is marked other than any injury or other traumatin. filed within Elementary/Şecondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify) 3 Removal from State of Funeral Service Licenses 23a. Part1. Enter the diseashook or heart failure Do not enter the mode of duing, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-tran P.O. Box 68760. physician the I IF FEMALE: for use 23c. If yes, outcome pf pregnancy
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4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) the 9 Unknown þ After this certificate has been signed funeral director, page 2 should be det Part IJ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 1 Inpatient Certification: To After this 2 ☐ ER/Outpatient 3 ☐ DOA 5 PResidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 Natural (Month, Day Year) death. 1 Tyes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number Aate signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) ollhouse Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Bridgetorth Marie Dorothy /Medical 2009 4a. Facility Name (If not institution, give street and number, Examiner or Location of Death 4c. County of Death 8. Date of Birth (Month, Day Ye 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 F Months Days Hours 226.50. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be a difficed at Director MD Baltimore 1 XYes 2 No Mrdge Fort 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Kimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Years 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) French Bridgetorth 131 acknow Ida ပ္ 19a. Informant's Name/Relations p (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9504 Painted Tree Drive Randallstown MD 21132 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 10/20/09 Ceneter 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vinustra C. Steene Funeral SIO Jan Road Randall Stown MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to J s a consequence of): /Medical Examiner Sille (ell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Trit Examiner Thomboy topen n
Due to (or as a consequence of): attending physician and for use as the burial-tran P.O. Box 68760 Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 KNo 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 1 Yes 2 □ No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Pruneral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I To the 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month

09-08041 Siera Ball Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

era Ball		State of Maryland / Department of Certificate of			200	19 3344
Physician	_	1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Examine		Siera Ball		October 16	, 2009	1230 hrs
		4a. Facility Name (if not institution, give street and number)  Good Samaritan Hospital	b. City, Town, or Location of Death Baltimore	n	4c. County of Death	1
Funeral	T	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	_ ,		thplace (State or Foreign
Director		220-25-3986 1□M 27F 19 Yrs.	Months Days Hours Mir	11/08	11989 "	ountry) MD
è		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
d d	.	MD Baltimore Baltin	· · · · · · · · · · · · · · · · · · ·	0ak		1 Yes 2 X No
re Maryland or 28a-f show any fied at once.	<u>ا يو</u>	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	4932 Carmine Avenue	21207		usfl	
eath with the items 23a ust be noti	Jera L	1 X Never Married 2 Married Armed Forces? If You	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	rican Indian, Black,
ter dez		1 Yes 2 <b>X</b> No	Yes 2 X No specify:		Specify: B	ack
ours ad atural xamin	<u>8</u>		t's Usual Occupation (Give kind of ost of working life, DO NOT use re		16b. Kind of Business/	Industry
36 n 72 h nan "n lical E	Sete	Elementary/Secondary (0-12) College (1-4 or 5+)	Clerk	urcu)	D.L.	. 1
215-0036 be filed within 7 ntal Hygiene. Red other than ent, the Medica	Completed	17. Father's Name (First, Middle, Last)		ie (First, Middle, M	aiden Surname)	
215 be file ntal Hy riked o	Be	James Ball Sr.	Ken	ee C.	Jones	
3 5	٥	Share D. Harcum (Sister) 19b. Mailing	Address (Street and Number or	Rural Route Num	ber, City or Town, State	e, Zip Codala44
and 2 sho tealth and tem 27 is traumati	-	20a. Method of Disposition 20b. Place of Dispos	ition (Name of cemetery,	Date	20c. Location - City or	r Town, State
nore		1 Burial 2 Cremation 3 Removal from State	fe place)	.23.09	Baltimo	and or
Baltimore, permit. Pages I ar Department of Hee Important: If iter injury or other tr	ł	4 Donation 5 Other Specify:  21. Signature of Foneral Service Licensee	Name and Address of Pacility Grant Standard Stan	cene fu	neral Se	rurces
	_	23a. Part I. End the disease, or comblications that caused the death. Do not enter the	151 Balto. Na	t'I Pila	CZ1229	Approximate Interval
Physician /Medical	١	failure. List only one cause on each line.			St, SHOCK, OF HEAR	Between Onset and Death
taminer		Immediate Cause (Final disease or condition resulting in death)  a. Cardiac arrhythmia of Due to (or as a consequence of):	complicated by d	rowning		
	_	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):		<del>.</del>		-
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated				
recuted cecuted . transit		events resulting in death) Last Due to (or as a consequence of):				
0, e be execut /sician and burial - tra	edica		<del>r FH g<b>896 10/20,</b> Ba-f,permE, g898</del>		ጥጥ	
760, icate be physic the burn		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	
Box 6876( he death certificate the attending physhed for use as the b	Physician/M	past 12 months?  4 Pregnant at time of death 5 Ot	tal death 3 Ectopic pregr her (Specify)	nancy	Month	Day Year
Bo he deat the deat hed for	hys	1 Yes 2 No 9 V Unknown g Unknown	Det I	Tago, Did to	bacco use contribute to	o the cause of death?
		Part II. Other significant conditions contributing to death but not resulting in the user Seizure disorder	underlying cause given in Part I.			obably 4 Unknown
ds, require	Completed by	DOIDGIO GIDOFAOT		24a. Was a		utopsy findings available completion of cause of
of Vital Records, ing Physician: The law required the this certificate has been suneral director, page 2 should	gw			autop: perfor	med? death?	
an: The	ည္ ကို	25. Was case referred to medical	26.Place of Death (Chec			
Vita		examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient			Residence 6 Other	er:
n of Niding Ph.h.		27. Manner of Death  1 Natural 5 Pending  1.0 (1.0 (1.0 (1.0 (1.0 (1.0 (1.0 (1.0 (	Injury 28c. Injury at Work?		nowinjury occurred in bathtu	Ъ
r Atter er deat rrector	licati	2 X Accident Investigation 10/16/09 Link				Rural Route Number, City
Div	Certification:	3 Suicide 6 Could not be determined (Specify) residence		or Town, S 4117 Cet	<sup>tate)</sup> ntury Rd. 1	Baltimore, M
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director / completely filled in by the file.		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur one) Physician: To the basis of examination and/or investigation.	rred at the time, date and place, ar	nd due to the caus	e(s) and manner as sta	ated.
To the within To the comp	Medical	2 Medical Examiner. On the basis of examination and/of investigation and manner stated.  29b. Signature and title of certifier	29c. License number	at the time, date	29d. Date signed (M	
		Can de La Don.	O.C.M.E.		October 18, 200	
d	ł	30. Name and address of person who completed cause of death (Item 23a)			l	
$\varphi$		Carol Allan, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 212	201		
Sta Registr	te	31. Date filed (Month, Day, Year) 2005 32. Registrar's Signature	rankel			

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

09-07916	
Danel Brown	

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Low	1		w	"not	- 17	. 3	-0.0

		1- For State Certificate Registrar	e of Death	Reg. No.
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last)  R. Brown	Mont	of Death h Day Year ober 12, 2009 3. Time of Death 0126 hrs
		4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 220 - 29 · 0603 1 M 2 F	*	e of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
nd how any ce.		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or	Location altimore	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 2856 Gatehouse Drive	10f. Zip Code 2(207	10g. Citizen of What Country? USA
r death wi	Funeral	11. Marital Status  1 Never Married 2 Married  1 Yes 2 No  3 Widowed 4 Divorced If Yes. Give Year	3. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, e  1 Yes 2 No specify:	
64 3 1	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	cedent's Usual Occupation (Give kind of work don ring most of working life, DO NOT use retired)	1
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	Be Comp	17. Father's Name (First, Middle, Last)  Clyde Brown	aycare Instructor  18.Mother's Name (First, N	diddle, Maiden Surname)
AD 2 2 shou 1 and N 27 is n		19a. Info mant's Name/Relationship (Type, Print)  Clyde Brown/Father 5.	Mailing Address (Street and Number or Rural Ro 303 Liberty Heigh	ute Number, City or Town, State, Zip Code) 21267  MS AVENUO Balto MD
Page ment c		1 X Rurial 2 Cremation 3 Removal from State crematory	Disposition (Name of cemeter() Dave or other place)  Lemonous Park 10 17	20c. Location - City or Town, State  OP Windsor Mill, MD  n.C. Greene Funery SVCS
Balt Bernit Depart Impor injury		23a. Part I. Enter the disease, or complications that caused the death. Do not e	8128 Liberty Koda	Kandalistown MD 21133
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  an	fection complicated by d obesity	pneumonia Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
		events resulting in death) Last Due to (or as a consequence of):  d.	d ner MF g896 10/21/09	TT
8760, ifficate be execut ong physician and as the burial - tran	≅ I2	IF FEMALE: 23c. If yes, outcome of pregnancy	d per ME g896 10/21/09 g897 11/9/09 TT  Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
that the death certif	Physician	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)	
rds, P.O. requires that the been signed by hould be detact	≥∣	Part II. Other significant conditions contributing to death but not resulting ir	1	e. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 ✓ Unknown  a. Was an 124b. Were autopsy findings available
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Completed		1.	autopsy prior to completion of cause of death?  Yes 2 No 1 Yes 2 No
Vital Rec	Re	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outp	26.Place of Death (Check only one patient 3 DOA Other'4 Nursing Home	
ion of Vil tending Physic eath. tor: After this	tion: To	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)		escribe how injury occurred
Division To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the		2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  Accident Investigation 28e. Place of Injury - At home, farm (Specify)		cation (Street and Number or Rural Route Number, City Town, State)
To the Hos within 24 h To the Fun	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner:On the basis of examination and/or invession and manner stated.	estigation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
		29b. Signature and title of certifier  M. U	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 12, 2009
$\emptyset$		Name and address of pers / who completed cause of death (Item 23a)     Jack Titus MD.	Penn Street, Baltimore, MD 21201	
Sta Registr	te ar	31. Date filed (Month, Day, Your San 32. Registrar's Signature	Kel	

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Physician/Medical þ Completed Be Certification: Director: din by the f Medical

Natural

Suicide

Accident

2

this certificate

After

ON ENDED	AMENDED	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnan 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of delivery  Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 ✓ No 3 Probably 4 Unknown
		24a. Was an autopsy findings availab prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
25. Was case referred to medical	26.Place of Death (Check of	nly one)
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing	Home 5 Residence 6 Other: Scene
27 Manner of Death	28a Date of Injury 28h Time of Injury 28c Injury at Work?	28d Describe how injury occurred

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E October 14, 2009

Subject shot

Assistant Medical Examiner

(Specify) Single Family

Oct 13, 2009

Zabiullah Ali, M.D. 31. Date filed (Month, 2. Registrar's Signafure

Pending

Investigation

Could not be

determined

111 Penn Street, Baltimore, MD 21201

Yes 2 ✔ No

28f. Location (Street and Number or Rural Route Number, City

or Town, State) 10201 Harrison Grant Drive, Woodstock, MD

State Registrar 0335 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

	ı
Physician	
/Medical	l
English to the same	ı

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment is set to notified any injury or other traumatic event, the Modical Experiment is set to notified and any injury or other traumatic event, the Modical Experiment is set to a notified and any injury or other traumatic event, the Modical Experiment.

Baltimore, Maryland 21215-0036

Physiciar /Medica Examine

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	FUI	Certificate of Death	Reg. No.	0 0 4 4 4								
cian	Decedent's Name (First, Middle, Last)     Richard Paul Blanchard		2. Date of Death Month Day October 18, 200	3. Time of Death								
lical iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat										
	7615 Daniels Avenue	Parkville	Baltin	more								
ıl r	213-20-0733	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. E	Birthplace (State or Foreign Country) ary Land								
ctor	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 ☐ Yes 2 🌠 No									
al Dire	7615 Daniels Avenue	10g. Citizen of What (	Country?									
Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Korean	13. Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.) 14. Race - Ar Black, Wt Specify: Wt									
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  1 2 2	rking 16b. Kind of Busines Hedwin Co	orporation									
To Be Co	17. Father's Name (First, Middle, Last)  Joseph Elliott Blanchard		me (First, Middle, Maiden Surname)  Lenore Bremic	k								
-	19a. Informant's Name/Relationship (Type. Print)  Michele Kuenzel/Daughter  19b. 1	Mailing Address (Street and Number or A 43 Saxon Circle,	ural Route Number, City or Town, State Baltimore, MD 2	e, Zip Code) 1 2 3 6								
	20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery,											
ACTION .	21. Signature of Euneral Service Licenser	serviæs 21234										
Examiner	23. Part in Enter the disease, or complications that caused the death. Do not ship ck, or heart failure. List only one cause or each line.  In me yate Cause (Final deeper or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. First underthing Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of Due to (or	):	c or respiratory arrest,	Approximate Interval Between Onset and Death								
Aedical	d	23d. Date of Month	delivery Day Year									
ed by Phy	Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute	e to the cause of death?  Probably 4  Unknown									
Completed by Physician/	COL PULINCHALE		autopsy prior performed? death	autopsy findings available to completion of cause of !? es 2 □ No								
Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Other:	ath (Check only one)									
Certification: To	27. Manner of Death 28a. Date of Injury 28b. Ti	Datient 3 DOA 4 Nursing	Home 5  Residence 6 ☐ Other (S 28d. Describe how injury occurred	pecify)								
Sertifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,								
Medical C	29a. Certifier (Check only one)  17 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occ	re, and due to the cause(s) and manne curred at the time, date and place, and o	r as stated. due to the cause(s)								
×	29b. Signature and title of certifier  29d. Date signed (Month, Day, Year)  10 (19 (09)											
-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHULUS ECK IN 4920 Cayyfull Rud, Bult, WW 2/236											
tate trar	31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature	parker		,								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death **Physician** Month ber 200 Bernard Bourke Bowen Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore washington Medical Center Glen Burnie Anne Arunde 8. Date of Birth (Month, Day, )
Nov. 25, 5. Social Security Number Sex\_ 1☐M 2☐F (In vrs. last birthday Birthplace (State or Foreign Country) Funeral Year, Months Days Hours Min 218-44-1625 Nov. Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Experies, must be notified Director 1 ☐Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 867 Evergreen Road 21144 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ĀNo White If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if fiem 27 is marked other than "na any injury or other traumatic event and once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher Warehouse 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Bourke Bowen Sr. Helen Betty Moran ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Christina Bowen/Wife 867 Evergreen Road Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October Meadowridge Mem. Park 4 Donation 5 Dother (Specify) 2009 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation MO/357 Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final assive **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) the 1 □Yes 2 □No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy The 2 No 1 □Yes 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manney f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Latural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

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Bower

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FLORINE OCTOBER BRETHOLZ 2009 16 6:30 Ρ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BALTIMORE Examiner 4b. City, Town, or Location of Death GILCHRIST HOSPICE CARE TOWSON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 78 Yrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 218-28-9165 1 DM 2 X F Months Days Hours 0771871931 Director Yrs. Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10b. County Director 10a. State 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE **BALTIMORE** 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Funeral 3318 MARNAT ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc or, þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Marylahd 21215-0036 1 Yes 2 XNo Specify ON WHITE "natural", Completed 3 Divorced Specify: Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL OFFICE MEDICAL SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ARCHIE COHEN **JEANETTE ECHISON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEO BRETHOLZ / HUSBAND 3318 MARNAT ROAD BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State RANDALLSTOWN, MD 4 Donation 5 Other (Specify) CHEVRA AHAVAS CHESED 10/19/2009 22. Name and Address of Facility SOL LEVINSON & BROS Funeral Service Lice 8900 REISTERSTOWN RŌAD 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2/ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes မြ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28b. Time of Date of injury Certificate: 28c. Injury at 1 Natural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Fractioner: To the best daily knowledge, death accounted at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number + CONFUNITOD 10/17 30. Name and address of person who completed cause of death/(Item 23a) (Type, Print) 555W. Touson tour blud TOWING, MO ZIZOY lennawi

DHMH 17 Rev 7/2009

Registrar

31. Date (Month, Day, Year)
OCT- 2 0 2009

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year **Physician** 13,  $P^{M}$ 2009 4:50 Hubert C. Broadwater October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Months Days Hours Min. Yrs. Director 218-16-2924 Mar. 14, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2√ No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2112 Creek Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ es 2 □ No If Yes, Give Year or Dates: ₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or item any injury or other traumatic event, if a l'adical Examine 100e. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 years Pipe Fitter Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Manley Broadwater Eva Rosenberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Newbert (Granddaughter) 302 Glen Ridge Road Havertown, <u>Pa. 19083</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 kg Burial 2 ☐ Cremation 3 ☐ Removal from State ↓ Donation 5 ☐ Other (Specify) Bacred Heart of Jesus 10/16/2009 | Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc
Maryland 21 22. Name and Address of Facility 7922 Wise Avenue Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician reek disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical nse IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate | performed's 2 HNO 1 ☐Yes 2 ☐No 1 ☐Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 1No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lapa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month VENTON T. BROOKS 7:03 PM OCTORER /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHN'S HOPKINS BAYVIEW MEDICAL CENTER RALTI MARE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day) **Funeral** Year) Days 1 → M 2 □ F Director 220-36-5932 May 23,1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 □Yes 2 TXNo Dunda1k Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21222 23a 8057 Park Haven Road United States Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. hours after ∏Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 'natural", or 1 ☐ Yes 2 X No þ Specify Specify: 3☐Widowed 4☐Divorced Year or Dates: 1958-1962 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) i 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Steel Worker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should ပ Joseph V. Brooks Florence T. Gavenis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important; If item 27 is 2504 Ambler Road Dundalk, Maryland Theresa Merritt (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem, 10/19/2009 Baltimore, Maryland 21. Signature of Fune al Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Johns 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANOXIC BRAIN INJURY DAYS 5 disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner DAYS CARDIAC APPEST Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to or as a consequence of The law requires that the death certificate be executed 3 YEARS Exami CHRONIC OBSTRUCTIVE PULLIGNARY DISEASE and burial-tra Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Year 4 Pregnant at time of death Month Day 5 Other (specify) the detached ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 □Yes 1 ☐ Yes 2 ☐ No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending s after death. investigation 2 Accident 1 ☐ Yes 2 □ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral [ Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the within ? 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTORER 14 2009 Tu RES-000 ween.

Registrar

State

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

BALTIHORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVENUE

32. Régistrar's Signature

BENJAMIN TU IND

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month George Edward Carter 7:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 🗆 F Hours (Month, Day, Year) Director 215-40-2396 Mary Tand 66 09/07/1943 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location with the Maryland Director 10d. Inside City Limits 1 🗆 Yes 2 😾 No MD Carroll Union Bridge <sup>10e, Street and Number</sup> 3690 Middleburg Road 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21791 Funeral 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married þ 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Army the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Roofer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geroge Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Liberty Street, Westminster, MD 21187 Nathan Gibson/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Ardent Cremation Services: 10/20/2009 Hanover, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Ardent Cremation Services Laura C. Hardesty MO1197 7522 Connelley Drive, Ste.N. Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY PAILURE Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner ECURRENT Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit STAGE that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day 5 Other (specify) Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner<sup>4</sup> Hospital 24 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 A Natural 5 Pending 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) MOKAMME who completed cause of death (Item 23a) (Type, Print) ANTIET State arto Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year LISE 2009 04:18 PM 10 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samanitan Hospite Baltimore . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 N F Months Days Hours Min Director Usual Residence of Decedent 10a. State 10h County ns 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** MD Baltimore death with the 10e. Street and Number 10g. Citizen of What Country? 1. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Deportment of Health and Mental Hygiene "inturer", or item important: if item 27 is marked other than "natural", or item any njury or other traumatic event, the "Modical Evanthat" process Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 □Yes 2 No Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ဂ္ဂ 19a. Informant's Name/Relationship (Type. Fire Daughter) 19b. Mailing Address (Street and Number wural Route Number, City or Town, State, Zip Code) 130140.MP21206 00 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21/2009 Battimore, M.D. 21. Signature of Funeral Serv ce Licensee Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of using, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) SE P 5 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> ISCHEMIC CAPDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed KIDNEY END STAGE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 : autopsy performed certificate of Vital 1 □ Yes 2 □ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Division Hospital or Attending To the Hospiter County within 24 hours after death.

To the Funeral Director: After a funeral principle in the funeral pr 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wow MID ()MPS-23986 10-15-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohan Rudrappa Good Samanitan Hospital, S601 Loch Raven Blud, Belltimore 21239

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

20

Degistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year eu 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and n 4c. County of Death Examiner Baltimore f Under 24 His 8. Date of Birth (Month, Day, Year) Dec 1, 1949 If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 ☑ M 2 ☐ F Maryland Director 59 217-56-5085 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at MD Harford Aberdeen Director 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Natural", or items 23a once. 34 W. Bel Air Avenue #2 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 🛛 No Specify. þ 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Carl Albert Crew Lydia Huggins ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland Hubner/friend 6202 Marluth Avenue; Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4□Donation 5₺Other (Specify) in State 21. Signature of Funeral Strvice Licensee 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Ronald rector 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCUD Physician /Medical Due to (or as a conseque Examiner Sequentially list conditions, Due to fair as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE nse yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 9□Unknown Day Year 5 ☐ Other (specify) ed by the a detached f 9 🗌 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 24a. Was an page 2 autopsy perform 1 Yes 2 2 **N**o 25. Was case referred to medical examiner? funeral director, Medical Certification: To Be 26. Place of Death Check only one) 2**™** No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Many of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural (Month, Day death. 2 Accident 1 🗌 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the filled in by the

> State Registrar

(Check only one)

29b. Signature/and title of certifier

completed cause of death (Item 23a) (Type, Print)

2. Registrar's

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LEE OYMER CORBIN, JR. October 16, 2009 9:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE Timonium Baltimore County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Pay, Year)
Jan 11, 1942 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Director 212-38-4413 67 Mary Land Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Maryland | Harford County 1 ☐ Yes 2 🕅 No White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4178 Norrisville Road 21161 USA 12. Was Decedent Ever in U.S. Armed Forces? 159-165 1 X Yes 2 \( \subseteq \text{No} \) No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 Divorced White Specify: 16,2009 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Oymer Corbin, Sr. Estella Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Mae Corbin (Wife) 4178 Norrisville Road, White Hall, Maryland 21161 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem Gridns 10/21/09 Timonium, Maryland 21. Si my Hot Filhera Selvice Comme <sup>22</sup> Name and Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Each Transport of The Land Address of Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any leading to immediate cause. Enter Underlying After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perforn After this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 X No Other: 욘 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending work 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the ☐ Accident☐ Suicide☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Régistrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2000 6:05 PM ELIZABETH STEFFENS COULSON october /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROLAND PARK PLACE HEALTHCARE CENTER N/A Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2X F 219-12-4019 Director 85 Dec 17, 1923 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director 1 Yes 2 □ No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 830 W. 40th Street 21211 **USA** Funeral 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Be Completed by 1 ☐ Yes 2 ☑ No Specify. Specify: 3 X Widowed 4 □ Divorced White traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Henry Steffens Marie Wilhemina Alma Mueller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trauone. John B. Coulson (Son) 118 Hawthorne Road, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Paul's Cemetery | 10/21/2009 Baltimore, Maryland 21. Signature of Funeral Service Dicenses

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End-stage chronic obstructive hung disease ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of): Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Dav Year 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death • Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I do abile Tax 013657 October 18,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOC FREGER 7. IS ABELLE 830 N. 40 th STREET, BALTIMORE, 500 21211 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Month esara 08:42 AM /Medical 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death. 4c. County of Death Ba Agnes Hos PITA timor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Fareign Country) **Funeral** 1 M 2 F Months Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination in the Inditional any pince. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Stlemoor Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dres 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify. \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
44eoss 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Eda Saint Desgraves ည 19a. Informant's Name/Relatio p (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) asthemoar raves/wite Rd. Windsor Hill, MD 21244 Liene Dorathy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method-of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/22 ison forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene funer sys augher 23a. Part 1. Enter the shock, or hear e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician myocardia disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence of): the attending physician the for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregrant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy be detached for Month Ye ar Day 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 🗆 No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Impatient P 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and the of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 landrea Saint 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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	Physici	an	1. Decedent's Name (First, Middle, Last)				ate of Death onth ober 1		3. Time of Death	
	/Medio Examir		Joseph G. Deega 4a. Facility Name (If not institution, give street and number)	<u> </u>	4b. City, Town, or Lo		oper 1	4c. County of Deat	1:37 p M	
			500 Limerick Cir., #102		Timoniu	ım		Balti		
	Funeral Director		090-12-2131 ¹\x <sup>M</sup> 2□ F	(In yrs. last birthday) 84 Yrs.		f Under 24 Hrs. 8. D. Hours Min. F.	nte of Birth Nonth Day, Ye	9. Birtl Co. New	hplace (State or Foreign untry) York	
	yland now		Usual Residence of Decedent           10a. State         10b. County         1	0c. City, Town or Lo	cation				10d. Inside City Limits	
	e Mary Ba-f sh	ctor	MD Baltimore	Timo	nium			1 □ Yes 2 🔯 No		
	a or 2	Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cor	•	
	ms 23	Funeral Director	500 Limerick Circle, #102  11. Marital Status  12. Was Decedent Eve	er in U.S. 13. \	21093 Nas Decedent of Hispa	anic Origin? (Specify Y Mexican, Puerto Rican	es or No-	U.S.A		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Executive must be recitified at once.	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Marr	1-'47		Mexican, Puerto Rican Specify:	etc.)	Black, White	white	
5-0	"natus	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done duri	on ing most of working	168	. Kind of Business/I		
212	d withir jiene.	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)		oo NOT use retired) Jent			F.B.I.		
nd	be filectal Hyg	Be	17. Father's Name (First, Middle, Last)			3. Mother's Name (Firs.	,	den Surname)		
r <u>yla</u>	d Meni d Meni narke natic	٩	George G. Deegan	T		Cecelia	٧.	Morr		
S S	nd 2 sl alth an 27 is r r traur	- 39	19a. Informant's Name/Relationship (Type. Print)   Harriette C. Deegan-wife			Number or Rural Rou r., #102,			ip Code) 1093	
Baltimore, Maryland	es 1 and 2 and 2 of Health a lf item 27 is or other trau		20a. Method of Disposition		sition (Name of natory or other place)	Date		Location - City or T	own, State	
ij	t. Pag rtment rtant: I		4 □ Donation 5 □ Other (Specify)	Hilltop S	erv Corp	10/13/0		Towson, M		
Ba	permi Depa Impo any Ir		21. Signature of Funeral Service Licensee William C		1020 TOLK	Rd., Towso	II, MU	Funeral H 21204	ome, Inc.	
8	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Acute Re	10a1 •					Approximate Interval Between Onset and Death Hours	
	/Medical Examiner		resulting in death)  a. Due to (or as a c	onsequence of):	/ Cod A	resk v 2			Hours	
		je e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a c	onsequence of):	LESPING	ATORY	FAI	LURED	Morths	
	ecuted nd transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	MONAF	Y FI	ATORY BROSI	5		VPANI	
58760,	ficate be executed I physician and s the burial-transit		resulting in death) Last Due to (or as a co	onsequence of):		-			1	
687	rtificate ng phy as the	<b>Nedical</b>	d							
O. Box	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at time 1 □ Pregnant at time 1 □ Vertical Pregnant at time 1 □ Vertica	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year	
S, P.	uires that the de	by Ph	Part II. Other significant conditions contributing to death but n	ot resulting in the un	derlying cause given in	n Part I. 23	Be. Did tobaco	co use contribute to	the cause of death?	
Records,	w requir s been s should	eted	LUNGES (IVE HE	ART 1	AILU	RE	1 🗆 Yes	2 No 3 Pro	bably 4 Unknown	
al Rec	siclan: The law certificate has t rector, page 2 s	Completed					la. Was an autopsy performed ⊒Yes 2	? prior to co	opsy findings available ompletion of cause of 2 No	
Vita	ysicla is certi directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	Others	. Place of Death (Che 4 ☐ Nursing Home 5		6 Flother (0)	-	
_ _	ding Physician:  After this certific funeral director,	H 1	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Ye	28b. Time of	28c. Injury at Work?			njury occurred	ity)	
Division of	ottendi death. ctor; A y the fu	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place of Injury	At home, farm, stre	M 1 □Yes	2 No	-1			
^	ital or At its after of ral Direct led in by	Certification:	4 Homicide determined 256. Flace of flighty building, etc. (6	Specify)	et, lactory, office	28ī. Lo Ci	cation (Street ly or Town, St	and Number or Rui ate)	al Route Number,	
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, to	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of many properties of examiner: On the basis of examiner and manner stated	amination and/or inv	occurred at the time, oestigation, in my opinion	date and place, and du on, death occurred at t	e to the caus ne time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
	P W H	Σ	29b. Signature and little of certifler	ino In	29c. License nui	5 P C	29d.	Date signed (Month)	Day, Year)	
			30. Name and address of person who completed cause of dead	(Item 23a) (Type, P	201 V	ORK R	d T	owsow.	WD 7120U	
	Stat Registra	Ŭ	31. Date filed (Month, Day, Year)  OCT 20 2009  Registrar's	Signature Sans	w		-11		7)	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10:25 Edward Vincent Deems /Medical October 13, 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cecil E1kton
If Under 1 Year If Under 24 Hrs. <u>Union Hospital</u> Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ▼M 2 □ F Maryĺand Director 1942 Feb. 6. 220-38-8254 Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination to notified at 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 2√2 No Director Colora Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21917 United States 123 Mt. Rocky Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify: White <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ba. Co. Fire Dept. Fire Fighter 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Edith Horning Paul Deems 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is Colora, Md. 21917 (Wife) 123 Mt. Rocky Lane Joyce E. Deems item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/16/2009 Baltimore, Md. Oak Lawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Den't 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure of shorts only one cause on each line. Approximate Interval Between Onset and Death shock, or near rand mmediate Cause (Final **Physician** Due to (or all a consequence of): disease or condition resulting in death) /Medical Examiner Ends tage rend Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence or) ii any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Severe Congestive end stage the burial-tran Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the detached 9 Unknown 9 Unknown funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed Ves 2X 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Phpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hypium 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Bow Street Elkton MOZISZI Hospiter 106 Lecky 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day, OCTOBER 2009 **Physician** 9:40 A M ROBERT EICHELBERGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 ⊠ M 2 □ F April 10, 1921 88 Director 172-14-6342 Mary Tand Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Medical Examination. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Director Harford Bel Air 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 300 W. Ring Factory Road #308 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ∐Yes 2 X No 1 ☐ Never Married 2 X Married Specify: White 1 ☐Yes 2X No Specify: If Yes. Give ģ 3 Widowed 4 Divorced Year or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) physicist research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Eugene Eichelberger Dorothy Louise Failinger ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Yosua/daughter 1003 Hillside View Road; Parkton, Maryland 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐ Other (Specify) Signature of Funeral Service Licent 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street ade, Director Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cerebalana disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2√QNo 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dand 5 D October 9, 2009 032259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD BEL AIR, MD. 31. Date filed (Month, Day, Year) State park OCT 20

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death **Physician** ARLO 12ABE 0511 10 VI /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis
Under 1 Year | If Under 24 Hrs. Arunde1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 4 F Months Days Min Hours 215-22-4710 82 **Director** 24,1926 Oct. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Mactal Expriner must be ratified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ANO Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7466 Furnace Branch Road 21060 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Joseph Craig Sr. ည Mary Frances Finn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr James J. Earle /Son 1412 Oakdale Road Glen Burnie Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2009 Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year ☐Yes 2. No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

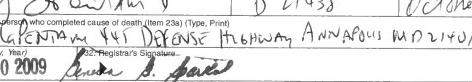
Medical

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year) OCT 20 2009

29b. Signature and title of certifie

30. Name and address:



DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_			1 - State Registrar					Certif	icate of	Deat	h		Reg. No.			1,51
	Physic	ian	1. Decedent's Name (Firs	t, <i>Middle, L</i> a	st)							2. Date of De	ath	- 3 <i>1 - 11 - 1</i>	3. Time	of Death
112	/Medi		Dorothy M.									Octobe:	r 12,	2009 <sup>ar</sup>	3:44	РМ м
	Exami	ner	4a. Facility Name (If not in					4b.	City, Town, o					ounty of Deat		
1			Upper Ches  5. Social Security Number											Harford		
	Funeral Director		216-14-009 Usual Residence of Deced	9   1	Бех □ М 2 <b>Т</b> F	7. Age (In yr			Under 1 Year onths Days	Hours	er 24 Hrs. s Min.	8. Date of Bir (Month, Da July 2	th 1, 19	Con	place (State intry) yland	0
	with the Maryland ta or 28a-f show			County	u	nk 10c. 0	City, Town	or Locatio	n						10d. Inside	City Limits
	a-fs	Director	PA				Del	ta							1 □Ye	s 2∭No
	or 28	Oire	10e. Street and Number						of. Zip Code			T	10g. Citize	en of What Cou	intry?	
	23a		101 Broad S	Street					17	314				USA		
T	tems 23	Funeral	11. Marital Status		12. Was Dece Armed For	dent Ever in rces?	U.S.	13. Was	Decedent of H	dispanic (	Origin? (Spe	cify Yes or No Rican, etc.)	- 14	Race - Amer Black, White		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Completed by F	1 □ Never Married 2  3 🎇 Widowed 4 □ D	ivorced	1 ∐Yes If Yes, Giv Year or Da	/e		_	′es 2∏No	Specia				pecify: wh		
15-	"natu	lete	15. Do (Specify only	ecedent's Ed v highest gra	lucation de completed)		16a.	Decedent's (Give kind	Usual Occup of work done OT use retired	ation during m	ost of workin	g l	16b. Kind	of Business/I	ndustry	
12	within iene. than "	μĔ	Elementary/Secondary (	0-12)	College (1	-4or 5+)							т.	1 . 1	1	
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an	should be nd Mental marked o	To Be							dirk	101 11101	anor o riamic	(* iist, middis,	maidon oc	arriame)		unk
ary $\otimes$	shou and N is mai		19a. Informant's Name/Re	elationship (	Type. Print)		19b.	Mailing Ad	dress (Street	and Num	ber or Rural	Route Numbe	er, City or T	Fown, State, Z	p Code)	
Ω <sub>Σ</sub>	1 and 2 Health a em 27 is		Robert Ensl	ey/so	n				oad Sti				17314		,,	
10/12/2000 T	Pages 1. nent of He int: If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem 4 ☑ Donation 5 ☐ O	nation 3 🗆		20b. State	Place of cemetery	Disposition y, cremator	(Name of y or other plac	ce)		ate		tion - City or T	own, State	
Baltir	permit. Pag Department Important: any injury o		21. Signature of Funeral Ron		- A.	irecto	r	1		_		655 W.	Balt	imore S	Street	
			23a. Part 1. Enter the dise	ase, or comp	olications that ca	aused the dea	ath. Do n	Balt ot enter the	imore,	MD ng such a	21201	respiratory at	reet		Approxima	ate
	Physician	6 6	Immediate Cause (Final	e. List only	one cause on ea	ach line.	00							coal	Interval Be Onset and	etween
6	Medical		disease or condition resulting in death)		a. Due to (	or as a conse	guence of		5 CUINIY	VICA	- 1	01880	40/1	1010		
世	Examiner		O		h -				MAN	Ary	EN	1Boli	RM			
00	pi ti	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	or as a conse	quence of	f):		1						
45	ecute and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last		c. C.D	1FF a	474	1 611	7H SY	18761	11CIN.	planna.	TORY !	RESPONS	G	
S (5	be ex ician a	Ê	resulting in death, Last													D.00 10
M8c044508∓ x 68760,	certificate be executed rding physician and ise as the burial-transit	Medical Examiner			d. Nevi/C	5 GX 10	1646	150 W	ON OF	- Uth	149NIC C	0155714	127100	FULLY.	Nysing V	113601
O.Box	death e atter d for u	by Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	arit j	23c. If yes, outo 1 ☐ Live bi 4 ☐ Pregn. 9 ☐ Unkno	irth 2 ☐ Fet ant at time of	al death	3 ☐ Ecto	pic pregnancy er (specify)	у			230	d. Date of deliv	ery Day	Year
7 9.	that ti	H.	Part II. Other significant c	onditions co	ontributing to dea	ath but not re	sulting in t	the underly	ing cause give	an in Part	1	23e Did to	hacco use	contribute to	he cause of	doath?
S S	law requires that the as been signed by th 2 should be detache	d b	0.3		9		g		ing caace give	on mr an			es 2 □ !		bably 4 🐧	
ecord	v req	lete														1
$\sim$ $\sim$	2 2 2	Completed										24a. Was a autop perfor	sy	24b. Were aut prior to co death?	opsy findings impletion of	available cause of
$\mathcal{L}$	ician; The certificate ector, pag		25. Was case referred to m	edical								1 □Yes	2 H/O	1 ☐ Yes	2 No	
	Physician; this certific ral director,	o Be	examiner? 1 ☐ Yes 2 No	100	Hospital:	patient 2	T FB/Outr	patient 3	Othe			(Check only or		70th /0		
Of	ding Phys n. After this funeral dir	<u> </u>	27. Manner of Death		28a. Date o		28b. Tir	me of	28c. Injury Work	-411		e 5 ∐ Hesid Bd. Describe h		Other (Speciocurred	fy)	
∯.	Attending r death. sctor: After by the funer	atio	2 ☐ Accident i	Pending nvestigation	(IVIOTIU)	i, Day, rear)	l inj	ury M		?? Yes 2 ⊑	]No					
PoT/+ Division	al or Attenss after deatl	Certification: To		Could not be determined	28e. Place o building	of Injury - At h g, etc. <i>(Spe</i> c	nome, farn	n, street, fa	ctory, office		28	3f. Location (S City or Tow	treet and N n, State)	Number or Rur	al Route Nui	mber,
Bol	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  Ce  2□ Me	rtifying Phy edical Exam	vsician: To the tiner: On the ba	SIS OF EXAMINE	owledge, ation and	death occu or investig	rred at the tin ation, in my o	ne, date a pinion, de	and place, and eath occurred	nd due to the o	cause(s) ar date and pla	nd manner as ace, and due t	stated. o the cause(	(s)
- 11	To the within 2 To the comple	ž	29b. Signature and title of c	ertifier	11				29c. License	number		12	29d. Date s	igned (Month,	Day, Year)	
	•		A	Li	there	2 /	4.0	)		21	5191	7	10/1	12/2	000	7
			30. Name and address of p			of death (Ite	m 23a) (T	ype, Print)			1		, -	12/2 C,MD-		
			AANURHA SI	RITH		60 GA	TEWA	94 DR	186,52	1116	2//22	B BG	LAIR	MD -	2/0/	4
	Stat	e	31. Date filed (Month, Day,	7°7 200	19 37 Re	gistrar's Sign	ature	back			/					

DHMH 17 Rev 1/2001

amend #9, Type or Print in Black Indeline Ensure 41 929 in Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 130 **Physician** 4 Anthony Edwards 04 09 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner REMAR. LAUENWOOD NSG. 4 Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Yrs Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 245 17 4/67 Mar 28. 1963 Delaware Director 46 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimen CA 1√2 Yes 2 □ No MID Baltomore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 501 W. Franklin Street 21201 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. unk 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: black ð 3 - Widowed 4 - Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant cook 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be Barbara Tinnin 2 19b. 14628Ad Sess Medan Sum Star RAptout 1203er, Bur Lingtonie Wee 27215 19a. in pomitalar Montigoin ery Prinsister 501 W. Franklin Street Baltimore, MD 21201 Ravenwood Nursing & Rehab 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or once. '4 □Donation 5 ♥Other (Specify) in state 21. Signatur of Function Structure Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 Deliciency Syndrone Auto immune Due to (or as a consequence of): Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? ģ

**Physician** /Medical Examiner

with the Maryland

death

77 is marked other then "neturel", or items 23a or 28e-f show treumatic event, the Modical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other then "neturel", or Item

Baltimore, Maryland 21215-0036

anding physician and use as the burial-transit atter for u isigned by the a been signated to should to certificate To the Hospitel or Attending Physicien: : After the Director: /

Completed

Be

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Certification:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

4405 Balkinory

1 Yes 2 No 3 Probably 4 Unknown

2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner 1 Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 🗀 Suicide

4 Thomicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

NO

D 43386

10-8.09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Homand 31. Date filed (Month, D.

5 Pending

6 Could not be determined

investigation

821 EUtim 3. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a

To the Funerel C

completely filled i

N.

			1 – For State Registrar	State	of Maryla		artment of ertificate of				giene, Reg. No.	000	33461
	Dhyojei	<b>.</b>	Decedent's Name (First, Middle 1)	e, Last)						Date of Dea     Month		Year	3. Time of Death
	Physici /Medio		Kose	Edga						OCTOBER	16	, 2009 county of Death	6:28 P <sup>M</sup>
j	Examin	ner	4a. Facility Name (If not institution STELLA MARIS	n, give street*and ni	umber)		4b. City, Town,		of Death			RE	
	Funeral Director		5. Social Security Number 165 – 16 – 5390	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In ye	rs. last birthday Yrs.	Months Days		Min.	8. Date of Birth (Month, Day 06/27/	1918	9. Birth Cou	pplace (State or Foreign intry) PA
	land bw		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or L	ocation						10d. Inside City Limits
	e Mary a-f sh	ctor	MD BAL	TIMORE			PARKVILL	Ë					1 □Yes 2 <b>X</b> 1No
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 9124 SUMMER	PARK DRIV	/E		10f. Zip Code	21234			10g. Citiz€	en of What Cou USA	untry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event har met be notified at once.	þ	11. Marital Status  1 □ Never Married 2 💢 Marr 3 □ Widowed 4 □ Divorced	Armed F	2 <b>∏</b> No aive	U.S. 13.	Was Decedent of If Yes, specify Cub 1 □Yes 2 XNo	oan, Mexica	n, Puerto I	ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: Wh	
<u>.</u>	72 ho "natur	leted	15. Deceden (Specify only higher	t's Education st grade completed	)	(Giv	edent's Usual Occu	durina mos	st of workin	ng	16b. Kind	d of Business/I	ndustry
717	d within giene. er than	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		PERFORMER	ed)			PERF	ORMING	ARTS
land	uld be filed Mental Hy rked othe rtic event,	To Be C	17. Father's Name (First, Middle, LOUIS	LEV]	I NE				er's Name ANNIE	(First, Middle,	Maiden Si GLA	,	
Mar	nd 2 shou lith and it 27 is ma r trauma		19a. Informant's Name/Relations WARREN EDGAR /			1	ing Address (Stree				-	Town, State, Z	
nore,	Pages 1 arent of Healent of Healent of Yealent of Yealent of Yealent of Yealent of Yealent of Yealent of Heale		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		n State	cemetery, cre	osition (Name of ematory or other pla RIENDSHIP			8/2009		ation - City or T	
Бант	permit. F Departme Importar any Injur		21. Signature of Funeral Service		7		22. Name and Addr				-		
İ			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the de								Approximate Interval Between
4.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. At	heros		re Caro	liov	alcr	1/ar	Disc	eovie	Onset and Death
1	Examiner			Due to	o (or as e cons	equence of):							
~	uted f insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		(or as a cons	equence of).							
0/00/0	icate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last	cDue to	(or as a cons	equence of):							
00	rtificate ng phy: as the		IS SEMILE	a									
C. DOX	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  25c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)								23	3d. Date of deli Month	very Day Year
cords, r.	equires that en signed by ould be deta	کِ	Part II. Other significant condition	ons contributing to	death but not r	esulting in the	underlying cause gi	ven in Part	l.		es 2		the cause of death?
al necc	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Completed								24a. Was a autop perfor 1 □ Yes	sy	prior to death?	topsy findings available ompletion of cause of 2  No
<u> </u>	rsiclan s certif lirector	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Innationt 2	☐ ER/Outpatie	ont all DOA Ot	h		(Check only or		Sother (Co.	sity) Huspice
SION OF	nding Phy th. : After this s funeral o	ition: To	27. Manner of Death  1 Abatural 5 Pendin 2 Accident investig	g 28a. Date (Mo.		28b. Time	of 28c. Inju	ıry at	2	28d. Describe h			(31)/1 (02) [12]
	al or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could a determ	ined 286. Plac	e of I <b>n</b> jury - At ding, etc. <i>(Spe</i>	home, farm, si	treet, factory, office		2	28f. Location (S City or Tow	treet and n, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier (Check only one)  12 Certifyir 2 Medical	ng Physician: To the Exeminer: On the and ma	ne best of my k basis of exam nner stated.	nowledge, dea ination and/or i	th occurred at the nvestigation, in my	time, date a opinion, de	and place, ath occurr	and due to the e	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
<b>.</b>	To the within to the comp.	Me	29b. Signature and title of certifie	r			29c. Licen	se number	5		29d. Date	signed (Month	n, Day, Year)
	6		30. Name and address of person	who completed cau			Print)	Rva	lV	Vejtr	yn,	iter	MD 21157
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 20 2	009 Sens	Registrar's Sig	nature	No						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 20a per dvr., g896, 10/20/19dpb certificate of Death Bog. No. 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Robert Feaster  $P^{M}$ 8:12 2009 August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) N/ABaltimore 1410 N. Potomac Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days Mary1and 08/06/1954 217-64**-7**400 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 □ No Baltimore N/AMaryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21213 1410 N. Potomac Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. Specify: African 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) City of Baltimore Waste Management 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nancy M. Means Hubert Feaster, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 408 Colleen Road, Baltimore, Maryland 21229 Quianna T. Feaster/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition

TEBuriat 2 ZCremation 3 ☐ Removal from State 08/14/2009 Catonsville, Maryland Metro Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street, Baltimore, MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death

or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours effer death.

To the Funeral Director: Affer this certific completely filled in by the funeral director.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rai', or items 23a or 28e-f ehow Examiner must be notified at

"natural"

permit. Pages 1 and 2 should be filed within 72 h Depertment of Health and Mental Hygiene. Important: If item 27 la markad other than "natur eny injury or other traumatic event, ILA Medical QDGB.

Physician /Medical Examiner

Director

by Funeral

Completed

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with the Maryland

Peges 1 end 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

disease or condition a.	Hypertensive Atherosclerotic Cardiovascular Disease						
resulting in death)	Due to (or as a consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions continued the continued of th	Due to (or as a consequence of):						
	Due to (or as a consequent	e of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	decedent pregnant   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)					23d. Date of delivery Month Day Year	
Part II. Other significant conditions control	ributing to death but not resulting	g in the underlying	cause given in Part I.	23e. Did tobacco		the cause of death?	
Chronic Drug Use, Diabetes Mellitus Type II,				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
Chronic Obstructive Pulmonary Disease  Chronic Obstructive Pulmonary Disease  24a. Was an autopsy performed? 1						utopsy findings availabl completion of cause of 2  No	
25. Was case referred to medical	26. Place of Death (Check only one)						
examiner?	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a, Certifier 1 (X) Certifying Physi	icien: To the best of my knowle er: On the basis of examination and manner stated.	dge, death occurre and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)	
29b. Signature and title of certifier			29c, License number 29d. Date		Date signed (Mon	th, Day, Year)	
1 hapart	udoga,	M.D.	D51318	10	1191	69	

State Registrar

1111 Washington Boulevard, Baltimore, Maryland 21230 Robert Cadogan, M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend # 10a-c,d,e,f, per Inf G896 10/28/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ oďťbber 18, 2009 12:55AM Virginia Lee Fisher Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Country) MD 06/06/ 215-12-5433 88 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** <del>Joppa</del> MD Harford **Baltimore** 1 X Yes 2X 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 914 Pine 21085 USA 3705 Evergreen Ave. 21206 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. Specify: White 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 ₩idowed 4 □ Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Retail Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles W. McHenry May L. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Pine Rd. Joppa, MD 21085 Raymond Fisher/Son Date 20, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 1 Burial 2 Cremation 3 Removal from State Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facili@AFA/Stephen D.Lohrmann P.A. MD 21286 8717 Green Pastures Balto. Dr. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral circtor, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performe 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) Honrawi 140 10/13/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) towsonton blid, Touson, MD Honnawims 555 W. 21204 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 9:08 AM 000000 James Willard Farrow Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 416 E. Patapsco Avenue #1 Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, (Month, Day, Tune 8, 1) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1⊠M 2□F Maryland 1944 65 Director 216-42-8720 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Motter Examiner must be notified #1 1 ☐Yes 2 ☑ No Director Baltimore Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with USA 21225 416 E. Patapsco Avenue #1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify. þ 1968 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Ruth Mildred Graves James Willard Farrow Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 416 E. Patapsco Avenue #1; Baltimore, Maryland 21225 Carol R. Ferhrmann/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) State Anatomy Board; 655 W. Baltimore Street 21. Signature A Fineral Service Licens 1. Ona 1 d S Wilder Darector Baltimore, Maryland 21201 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Immediate Cal se (Final disease or condition resulting in death) **Physician** una Cance /Medical Due to (or as sonsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed -tran and Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □Yes 2 □ No 5 ☐ Other (specify) Pregnant at time of death P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 1 ☐Yes 2 ☐No 2 **A** No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1145931 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLDOWITED Randallstown MD 5401 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2009 Month **Physician** 2:37 p. M. Frances Florence Goralski 0 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner are ca Date of Birth (Month, Day, Year) 12-3-1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🔀 F Months Days Hours Mary Land 212-30-1859 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinational Department of the Depar 10a State 10b. County 1X Yes 2 □ No Director MD Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 2520 Marbourne Avenue 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2X No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of MD Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Kowalski Anna Sobotka ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 239 Green Fern Way Baltimore MD 21227 Stephen M. Goralski 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-19-2009 Atlantic Crematory Glen Burnie MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ambrose Funeral Home Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiae or respiratory arrest, pp oximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial UNKNOLLU disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buriar 68760 Physician/Medical IF FEMALE: Division of Vital Records, P.O. Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy mately, trantes in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 October 30. Name and Adress of person who completed cause of death (Item 23a) (Type, Print)

Jen Holer, MD St. Agnes Hosp. ta 1 900 Contan Avenue Baltimuse,

State Registrar 31. Date filed (Month, Day, Year) 32.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DCTOBER 15 GURWITZ 2009 TERESA 11:54 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 09-13-195 Director 217-62-0194 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 FARMHOUSE COURT 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 X No þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OFFICE MANAGER ADOPTION ALLIANCE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ARNOLD **BLACK** SELMA WEINER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN GURWITZ/HUSBAND FARMHOUSE COURT, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ARL'INGTON"CEMETERY 4 ☐ Decation 5 ☐ Other (Specify) 10-18-2009 BALTIMORE, MD 21. Sign Jure of Funeral Service Liver SOL LEVINSON & BROTHERS, INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. MALIGNAM Onset and Death Immediate Cause (Final Providiciano FEBRUSHEU 2007 disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any leading to impectate cause. Enter Underlying Examiner ng. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 menths? Month Year the 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, To the Hospital or Attending Physician; The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X**00 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occured at the time, date and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 6701 NCHARLES ST, SUITE 405 BALTIMORE, MD 21204 DOBERMAN.MA State Registrar

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State Registrar (Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

To the !

lenegar, Catherine

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0061907

Ebo, 1124 Mace Avenue, Bultimore MD 21221

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2009 1 tobe /Medical 4c. County of Death Town, or Location of Death Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Edreign If Unde **Funeral** Days 1 □ M 2 💢 F Gountry) Yrs Director Jan. 10 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Evaluation and injury or other traumatic event, it is Madical Evaluation. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1XYes 2 □ No Director stou mor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt. 2 A by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 14. Race 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 X Divorced a Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Na /Relationship (Type. Print) ( aughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or To n, State, Zip Code) tes 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City of Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify) Entombrent 22. Name and Address of Facility 0.5.e.h. L. Russ -2.2. W. North 21. Signatore of Funeral Service Licensee Ave. Ba Home Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part # Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, the state of the sequence of the Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 cate has been signated by 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 10 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural s after dea... al Director: Aff 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11401 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>D</sup>14,2009 Physician/ Betty Hyatt October 2:10P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 219-10-2730 Months Davs Hours Min. 01/12/1926 COMPTS! Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore MD Yes 2 No 10f. Zip Code 21231 10g. Citizen of What Country? 10e. Street and Number 1701 East Baltimore St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. White 27 is marked other than "natural", or itraumatic event, the Medical Examin þ 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 the Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working Community Org. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Ret. Community Organizer Be 18. Mother's Name (Eirst, Middle, Maiden Sumame)
Mindel Besser 17. Father's Name (First, Middle, Last) Joseph Abraham Tomsky 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen McCahill/in-Law 623 St. John's Rd. Balto. MD 21210 20c. Location - City or Town, State Beltsville, MD 20a Method of Disposition 20b. Place of Disposition (Name of Oct. Date 16, cemetery, crematory or other place) 1 Burial 2 remation 3 Removal from State Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facill CAFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licensee MD 21286 8717 Green Pastures Dr. Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and be detached for use as the burlal-transit Adeno caranoma pnman that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Vnknown Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has autonsy death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Association, Hospital Other: 2 X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/15/09 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

HYATT

Easten Ave

32. Registrar's Signature

4940

Rachel Levine 31. Date filed (Month, Day, Year)

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		·	For State Registrar		State of Ma	aryland	•	artment of l rtificate of	lealth and l	Mental Hy	giene Reg. No.	39 33470
	Physici /Medic		1. Decedent's Nam	e (First, Middle, Las	n. Ho	LAC	rel			2. Date of De Month	Day 5 á	Year 8:30 p M
	Examir	er	4a. Facility Name (		street and number)	>V:\/	2	4b. City, Town, o	r Location of Death	1	4c. County	of Death
I	Funeral Director		5. Social Security N 217-34-48	6. So 369		e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 26,	iy, Year) _	9. Birthplace (State or Foreign Country) Maryland
	yland now		Usual Residence o 10a. State	10b. County			Town or Lo					10d. Inside City Limits
	he Mar 28a-f sl	ector	MD  10e. Street and Nu	Carro	11	El	dersb	urg			10g. Citizen of W	1 □Yes 24 No
	th with	al Dii		y Serra D:	rive #2A			21784			USA	mac country:
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Maries Examinatings to relified at	by Funeral Director	11. Marital Status 1 □ Never Marr 3 🏿 Widowed	ied 2□ Married 4□ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ ! If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 □Yes 2X No	Hispanic Origin? (Sl an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		e - American Indian, k, White, etc. · white
15-0	n 72 ho "natur	Completed by	(Spec	15. Decedent's Ed	ucation de completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	king	16b. Kind of Bu	siness/Industry
212	filed within Hygiene. other than "	Somp	Elementary/Second 12	ondary (0-12)	College (1-4or 5	i+)		memaker			own h	ome
and	uld be filed withi Mental Hygiene. arked other thar atic event, IIv.	Be		(First, Middle, Last)						,	, Maiden Surnam	
aryla	should be and Mental is marked of aumatic ev	입		Abner Dot:			19b. Mailir	ng Address (Street	and Number or Ru		halmeime er, City or Town,	
Š,	1 and 2 Health a tem 27 is		Tom Happ									aryland 21162
Baltimore, Maryland 21215-0036	Page nent c int: If iry or		4 ☐ Donation	□ Cremation 3 □ 5 □ Other (Specif)	)	20b. Pla cen		sition (Name of natory or other pla		Date		City or Town, State
Ball	permit. Pag Department Important: I any injury o		21. Signature of Fu	ineral Service Licen Ital d. S. W.	ade, Dive	ter		Market Control of the	ess of Facility Omy Board Maryland		. Baltim	ore,Street
	Physician /Medical Examiner		23a. Part 1 Enter t shock or hea Immediate Cause disease or condition resulting in death)	art failure. List only o (Final	a. Due to (or as	3114		er the mode of dy	ng, such as cardiac	or respiratory a	urest,	Approximate Interval Between Onset and Death
68760,	cate be executed obysician and the burial-transit	dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	S	b. Due to (or as  c. Due to (or as  d.							
.O. Box 6	The law requires that the death certificate be exite has been signed by the attending physician age 2 should be detached for use as the burian	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1	months? ⊒No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3 [	Ectopic pregnand Other (specify)	су		23d. Dat Mo	e of delivery nth Day Year
ords, P.	w requires that the disbeen signed by the should be detached	à	Part II. Other signif	ficant conditions of	entributing to death be	not resulti	ing in the u	nderlying cause giv	ven in Part I.	12	Yes 2□No	ibute to the cause of death?  3 Probably 4 Unknown
		Completed	OF Man ann refere	red to medical.						1 □ Yes	psy ormed?	Were autopsy findings available prior to completion of cause of death? ☐ Yes 2 ☐ No
f Vii	<u>~</u> . <u>≈</u>	To Be	25. Was case refer examiner? 1 ☐ Yes 2		Hospital: 1 ☐ Inpatie	ent 2 🗆 El	R/Outpatier	nt 3 □ DOA Oth	26. Place of Dea ner: 4 ☐ Nursing H		one) idence 6 □Oth	er (Specify)
o uc	ding Ph h. After thi funeral	ion:	27. Manne of Deat 1 Natural	h 5 ☐ Pending investigation	28a. Date of Inju (Month, Da	ry 2 y, Year) 2	8b. Time of Injury	Wor	ryat 'k? IYes 2 □ No	28d. Describe	how injury occurr	ed
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	<ul><li> Accident</li><li>3 ☐ Suicide</li><li>4 ☐ Homicide</li></ul>	6 Could not be determined	28e. Place of Injubuilding, etc	ury - At hom c. (Specify)	e, farm, str	eet, factory, office	TIES ZEINO		Street and Numb wn, State)	er or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical C	29a. Certifier (Check only one)		ysician: To the best liner: On the basis o and manner sta	f examination						anner as stated. and due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and	title of certifier	and mariner ste	ateu.		29c. Licens	se number	/	29d. Date signed	(Mgnth, Day, Year)
			30. Name and add	ess of person who o	pmpleted cause of d	eath (Item 2	23a) (Type,	Print) On-	er (+	Mach	noutch	WID 21157
	Sta Registr		31) Date filed (Mon	th; Day, Year) 200	9 S. Registra	ar's Signa	re pa	S. CCII	W 31.	1 46 21	MINSIC	1 1000 -110 7

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Ho LiteY, perRRYC Baltimore, Maryland 21215-0036

Pages 1

/Medical Examiner The law requires that the death certificate be executed physician for signed I I be det To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

Physicia	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (				Month Day	Year
by		contributing to death but not resulting in the N, DIABETES M	, ,				se contribute to the caus  ☐ No 3 ☐ Probably	se of death?
Completed	H/O BREAST	CANCER			per	s an opsy formed? 2 No	24b. Were autopsy fin prior to completio death? 1 ☐ Yes 2 ☑ N	n of cause of
Be	25. Was case referred to medical			26. Place of Dea	th (Check only	one)		
고 모	examiner? 1 ☐ Yes 2 No	Hospital: Inpatient 2 ☐ ER/Outp	atient 3□ [	OOA Other: 4 Nursing H	sidence 6	□Other (Specify)		
	27. Manner of Death  ↑☑ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tin		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred	
Certification	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	, street, facto	ory, office	28f. Location City or To	(Street and own, State)	d Number or Rural Route	9 Number,
Medical (		nysician: To the best of my knowledge, miner: On the basis of examination and/ and manner stated.						ause(s)
ž	29b. Signature and title of certifier	*	2	9c. License number		29d, Date	e signed (Month, Dav. Y	'ear)

29b. Signature and title of certifier

29c. License number RESODO 29d. Date signed (Month, Day, Year)

OCT 16, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANTONY DIFITAL. GOOD JAMARITAN HOSPITAL, 5601 LOCH RAVEN BLUD BALTIMORE, ND 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13, 2009 8:35 P M Betty Jane Hoffman October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year July 18, 1 **Funeral** Months Davs Hours Min. Director 78 1931 Maryland 214-28-6154 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinating the natified at 1865341750 10/13/09 2035 PM Baltimore, Maryland 21219-0036 Director 1 ☐ Yes 2 ☑ No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21085 2700 Greenspring Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify ð Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion Lavinia Tregoning Wilmer Clyde Rippeon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 Greenspring Avenue, Joppa, Maryland, 21085 Meral H. Hoffman / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Services Corp. 10/19/09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Intracrania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any ling to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Vital 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of Natural Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie D60768 0 Uffer Chesapeak Mu hammag

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** 10 16 0 /Medical ne (If not institution, give street and number ation of Death Examiner and allestons 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/22/1924 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Min. 219-12-9034 Director .MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show Director N/A BALTIMORE 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 CLARKS LANE. #811 Funeral 21215 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No WHITE Specify. 2 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 GOVERNMENT SECRETARY is marked other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othany injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL HOFFMAN ပ HANNAH ANSELVITCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STUART GOLDMAN / NEPHEW 10001 WINDSTREAM DRIVE, #302, COLUMBIA, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MOSES MONTIFIORE 4 Donation 5 Dother (Specify) 10/19/2009 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions. In any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-trar Due to (or as a consequence of) Box 68760 physician be Physician/Medical The law requires that the death certificate the attending p IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe 1 ☐ Yes 2 No Hospital or Attending Physician: ippatient director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No. Other: 4 Nursing Home 5 Residence 1 Tes nospie within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature of certifie

State

Registrar

30. Name and a

Grd. Eldesbu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 18. 2009 Harrell Deborah Ann 10:00 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Baltimore 5214 Tranore Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 1□ M 2 F Months Days Hours Min. 50 07-17-1959 Maryland 214-80-9390 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City. Town or Location 10b. County 1 ¥Yes 2 □ No N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5214 Tranore Road 21214 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 ☐ Married 1 ☐Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert E. Harrell Dolores Romia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21214 5214 Tranore Road Dolores Harrell - Mother 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State Hilltop Service Corp. 10-22-2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licenses .22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Betwee Onset and Deat Immediate Cause (Final CRC disease or condition resulting in death) D (or as a consequence of): o (or a a consequence of) They mom Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2ETNo

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

P.O. Box 68760,

Division of Vital Records,

this certificate has been signed by the attending physician and at director, page 2 should be detached for use as the burial-transit

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

\$

Completed

Be

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

State

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "nedgal Experience, ust be redfilled at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If flear 27 is marked other than "natural" pages any Injury or other traumatic appear.

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

25. Was case referred to medical examiner? 1 ☐ Yes 27. Mann of Death

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

29c. License number DZZ717 JOS DIGITAL LIWTACUM

ternando

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

faco Nis

Registrar DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral.

within 24 hours a To the Funeral L

Amend #8 per FH G896 10/29/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:20P M David Warren Harker OCTOBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6/4/1923. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 86 347-18-8627 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the List and Examinan must be rediffed at 1 □Yes 2XNo Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 United States 800 Southerly Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No If Yes, Give Year or Dates: WW II Specify Specify: white þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) social security administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Harker Laura Mae (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 Limerick Cir. Timonium, MD 21093 Carole Halverstadt/P.O.A. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardOct. 21,2009 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee Michell-Wiedefeld Funeral Home 6500 York Rd. Baltimore, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) HEMOPTYSIS /Medical Due to (or as a consequence of): Examiner PULMONARY INFARCT Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jua to (or as a consequence of): Examiner The law requires that the death certificate be executed and PHEMONARY EMBOLISM burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Lectopic pregnancy Month Dav Year 5 Other (specify) I □Yes 2 □ No Ö the detached 9 Unknown 9 Unknown signed by to be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CHRONIC OBSTRUCTIVE LUNG DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2▼No ATRIAL FIBRILLATION 24a, Was an cate has by certificate 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To the Hospita. Sure death.

To the Funeral Director. After this committeely filled in by the funeral director. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) **Medical** (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OŞLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Concern Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Mark Tyrone Johnson Certificate of Death 1- For State Reg. No. Registrar 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 13, 2009 Year 0900 hrs Medical Examiner urone c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3200 West Lexington Street 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 1 / M Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 Yes 2 No 28a-f show s 23a or 28a-f show e notified at once. Wynn 10g. Citizen of What Country? 10e. Street and Number 靣 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marikal Status tment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items;
y or other traumatic event, the Medical Examiner must be a Armed Forces? Never Married 2 No Yes 2 No specify If Yes, Give Year Yes Pages 1 and 2 should be filed within 72 hours after Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 pore Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Las Be (Street and Number or R 19b. Mailing Address inn Da 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 2 Cremation 3 Removal from State 10-19-2009 MID Donation 5 Other Specify gnature of Funeral Service Licensee 22. Name and ress of Facility Vaudh C sreene funeral Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or hear **Physician** Between Onset and only one cause on each line Death /Medical a. Gunshot Wound of Head Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical AMENDED UNPENDED y the attending physician thed for use as the burial Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Part II. Other significant conditions Yes 2 ✔ No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? The law 2 ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be examiner? Hospital: 1 Nursing Home 5 Residence 6 ✓ Other: Scene ER/Outpatient Inpatient 2 3 this 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) FOUND: After 27. Manner of Death 28b. Time of Injury Subject shot Certification: FOUND: Natural Yes 2 V No Pending Director: 0850 hrs Oct 13, 2009 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 3200 block west Lexington street, baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier October 14, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ìθ 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. egistrar's Signatur 31. Date filed (Mor Registra DCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 EUNICE COLL JAMES October 8:31 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County GILCHRIST CENTER Towson If Under 1 Year If Under 24 Hrs.

Heartha Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 💢 F Jan 12, 1911 Director 494-16-1751 98 Kansas Usual Residence of Decedent or 28a-f shove ne notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Towson 1 🗆 Yes 2 🕅 No 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o 21204 Funeral 615 Chestnut Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 🕅 Widowed 4 🗆 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pastry Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Schweibly ည Myrtle Orlie Coll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Hemingway Drive, Unit 1 B, Frederick, Dean Gordon Stark (Pers. Rep. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Green Mount Crematory 10/20/2009 Baltimore, Maryland 4 Depnation 5 Other (Specify) Signal of Fine Say College Martin D. Lawson MYTCHECC WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Di ath ong Physician/ disease or condition resulting in death) Medical Due to (or as some needuence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death ed by the a 9 I Hnknown 9 Unknown within 24 hours after death.

To the Funeral Director; After this certificate has been signed by is completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: ပ 1 ☐ Yes 2 Ø No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) George Honnawi 1017109

Registrar

DHMH 17 Rev 7/2009

State

Mari Ce

555 w. toursoton bevol, 16 ws si, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

KHIMAONI, MO

31. Date filed Month, Day, Year)

OCT

09-07995 Brian Lee Kacpura Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rian Lee Kacpura	1-	State of Maryland / Department For State Certificate	of Health and Mental H of Death	ygiene Reg. 1	20	no 221.7
Physician/	Re	distrar Decedent's Name (First, Middle,Last)	0, 200	2. Date of Death	av Year	3. Time of Death
Medical Examiner		Brian le Kacqura	4b. City. Town, or Location of Death	October 14, 2	2009 4c. County of Death	1825 hrs
	48	. Facility Name (if not institution, give street and number) 9306 Luray Drive	Parkville		Baltimore Cou	
Funeral	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24Hrs Months Days Hours Mir		MM/DD/YYYY) 9. Bir	thplace (State or Spurite Of Amole,
Director	0	10 00 0000	Yrs.	3-17-	1919 6	maryland
any		sual Residence of Decedent  Da. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show 1 at once ector	L	mo   baltmore   Park	ville	1100	Citizen of What Cou	
or 28a-	10	De. Street and Number	10f. Zip Code	Tog.	1), S. A	
r death with the Maryland or Items 23a or 28a-f sho must be notified at once Funeral Director	1	1. Margar Otatas	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No-	14. Race - Amer White, etc.	ican Indian, Black,
or Item	1	Never Married 2 Married Armed Forces?		o ricari, etc.)	Specify: W	rite
ural",		3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Dece	Yes 2 No specify: dent's Usual Occupation (Give kind of		6b. Kind of Business.	
5-0036 ed within 72 hour ygiene. other than "natu the Medical Exan Completed		Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use re	tired)	, Crea	1 1 0 -
5-0036 Ited within 72 Hygiene. I other than " the Medical.		7. Father's Name (First, Middle, Last)	artender 18.Mother's Nam	ne (First, Middle, Ma	SCSTAURA iden Surname)	nt & Dar
21215- uld be filed Mental Hyg marked oth		Walter Kappura.	Line	da Ch	risthi	1
Z = 8 = 5   0	F	9a. nformant's Name/Relationship (Type, Pril.) 19b. M	ailing Address (Street and Number of	Rural Route Number	er, City or Town, Stat	re, Zip Code)
nore, MD 2 ages 1 and 2 shou nt of Health and N i: If item 27 is re other traumatic	2	out Medica of Diopognon	sposition (Name of cemetery,	Date :	20c. Location - City o	or Town, State
More Pages 1 ient of H int: If i		1 Burial 2 Cremation 3 Removal from State crematory of 4 Donation 5 Other Specify:	Function (Chapel )	0/19/09	Forest 1	HIL MD
Baltimore, permit. Pages I al Department of He Important: If ite	12			Funeral		- Betarkvill
	12	33. Part I. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Appro mate Interval
Physician		failure. List only one cause on each line.  Immediate Cause (Final disease a. Pneumonia complica				Between Onset and Death
aminer		or condition resulting in death)  Due to (or as a consequence of): 21S	ease		Hr. Carrow Company	
1	<u>.</u>	Sequentially list conditions, fany, leading to immediate but to (or as a consecutions of):				
nsit Kamine		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
		#22 per Fh s	,896 10/20/09 TT			
0, e be execur sician and burial - tra		XUNPENDED 23a,27,perM	E, g898 12/2/09 T	T	23d. Date of delive	ery
the death certificate be the death certificate by the attending physic ched for use as the bure.	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  2c. It yes, outcome or pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg	gnancy	Month	Day Year
leath ce attend for use	SICI	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (Specify)			
		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob		to the cause of death?
Division of Vital Records, P.O. Is or Attending Physician: The law requires that the safe death.  The in Director: After this certificate has been signed by the funeral director, page 2 should be detach.	ed by			24a. Was a	n 24b. Were	autopsy findings available
Cord	Completed			autops perfor	ned? death	
tal Rection: The certificate ector, page	3	25. Was case referred to medical	26.Place of Death (Che	1 Yes 2	NO I	165 2 110
Division of Vital Final or Attending Physician: ours after death and a state of the craft filled in by the funeral director,		examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outp			Residence 6 🗸 Ot	her: Scene
n of ding Pl	ë	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Tin	ne of Injury 28c. Injury at Work?	28d, Describe n	ow injury occurred	
IVISION or Attend after death. Director:	icat.	2 Accident Investigation 28e. Place of Injury - At home, farm				Rural Route Number, City
DIV Ospital or hours afte uneral Dir	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, St		
C O S E E > 1		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one)  Wedical Examiner: On the basis of examination and/or invited by the control of the control	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due to	stated. o the cause(s)
within To the complete	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (	
		Theodor M. VielJA	O.C.M.E. 0	СМЕ	October 15, 20	009
		30. Name and address of person who completed clause of death (Item 23a)  Theodore M. King, Jr. M.D. Assistant Medical Evamin	er 111 Penn Street, Baltim	ore. MD 21201		
Sta	te	Theodore M. King, Jr., MD. Assistant Medical Examin 31. Date filed (Month, Day, Year) 33. Registrar's Signature		10.0, WD 21201		
Sta Registr	u.	OCT 2 0 2009 Prove S.	arked			

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exactinal format by notified at
Division of Vital Records, P.O. Box 68760分	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit on the transit of the completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of the completely filled in by the funeral director.

Physic /Medi Exami

Funeral Director

Registrar		С	ertificate of	Death	_	Reg. No.		P D I
1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	ath Day	Year	3. Time of Death
Abraham Kram	er					ber 16		3:45 PMM
4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Deat	h	4c. County	of Death	
Potomac Valley	Nursing Ce	nter	Rockv:	ille		Mon	tgomer	У
5. Social Security Number		e (In yrs. last birthda	Months Days	If Under 24 Hrs Hours Min.		h v. Yea <i>r</i> )	9. Birthplac	e (State or Foreig
111-07-2295	1 M 2 □ F	93 Yrs.	· Working Days	Tiodis Willia	Nov 0	6, 1915		
Usual Residence of Decedent		10 00 7					140.1	L-11-01-11-11
10a. State 10b. County		10c. City, Town or	Location				10d	Inside City Limits
DC		Washin	gton					1⊠Yes 2 No
10e. Street and Number			10f. Zip Code		==	10g. Citizen of	What Country	?
1847 Ontario P	lace NW		20009	1		Unite	d Stat	es
11. Marital Status	12. Was Decedent B	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (8	Specify Yes or No-	14. Rad	e - American	
1 ☐ Never Married 2 ☑ Marrie		10			to Hican, etc.)	Bla	ck, White, etc	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	ww TT	1 □ Yes 2 ⊠ No	Specify:		Specif	wh.	ite
15. Decedent's	Education	16a. De	cedent's Usual Occup	ation		16b. Kind of B	usiness/Indus	stry
(Specify only highest Elementary/Secondary (0-12)	<del>, , , , , , , , , , , , , , , , , , , </del>	(Gi	ive kind of work done of e. DO NOT use retired	during most of wo d)	rking			
12	College (1-4or 5		lesman			Whole	sale S	ales
17. Father's Name (First, Middle, L.	ast)			18. Mother's Na	me (First, Middle,			
Joseph Kramer				Julia	Fierman			
		405.34	ailing Address (Ctr. )			or City or Tarr	Ctat - 7'- 0	ada)
19a. Informant's Name/Relationshi <b>Evelyn Kramer</b>		1	ailing Address (Street					_ '
	/ WILE		347 Ontario					
20a. Method of Disposition 1  Burial 2  Cremation 3	3 Removal from State	20b. Place of Dis	sposition (Name of rematory or other place	ce)	Oct 21	20c. Location	· City or Towr	ı, State
4 □ Donation 5 □ Other (Spi		Mount I	Lebanon Ce	metery	2009	Adelph	ni, Mar	yland
21. Signature of Funeral Service Li	içensee,	M00382	22. Name and Addre	ss of Facility	N 1			
STALLA	of in a second	7700000	Rapp Fune				2001	0
23a. Part 1. Enter the disease, or o	complications that caused	the death. Do not e	933 Gist					pproximate
shock, or heart failure. List o	nly one cause on each lin	ie.		•	1	Para .	- In	iterval Between
Immediate Cause (Final disease or condition	_a. (avi	dio Va	is Corla	V AC	ade	t		
resulting in death)	Due to (or as a	a consequence of):	A 4	CuAti	Cide (Ses)	221		
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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a	a consequence of)	V 1	1				
Cause (Disease or injury that initiated events	С.					4		
resulting in death) Last	Due to (or as	a consequence of):	i i					
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23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 Ectopic pregnanc	у			te of delivery onth Da	
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (specify)					
		er man vancibleau la Alea	1 1 1		00 000		and the same of the	
Part II. Other significant condition	ns contributing to death bu	at not resulting in the	underlying cause giv	en in Part I.	23e. Did to	١		cause of death?
Part II. Other significant condition	ns contributing to death bu	at not resulting in the	e underlying cause giv	en in Part I.	23e. Did to	عد	tribute to the 3 ☐ Probab	
Part II. Other significant condition	ns contributing to death bu	at not resulting in the	e underlying cause giv	en in Part I.		res 2 No	3 ☐ Probab	ly 4 ☐ Unknowr
Part II. Other significant condition	s contributing to death bu	at not resulting in the	underlying cause giv	en in Part I.	1 □ Y	res 2 No an 24b.	3 ☐ Probab Were autops prior to comp death?	y findings available
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25. Was case referred to medical examiner? 1 □ Yes 2 ☑No  27. Manner of Death 1 ☑Natural 5 □ Pending investiga	Hospital: 1 □ Inpatie 28a. Date of Injur (Month, Day	nt 2 □ ER/Outpat	tient 3 □ DOA Oith	26 Place of De	1 \( \) Yes  24a. Was autop perform 1 \( \) Yes  ath (Check only only only only only only only only	res 2 No an 24b. sy rmed? 2 No ne)	3 ☐ Probab  Were autops: prior to comp death? 1 ☐ Yes 2	y findings available
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examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin  29a. Certifier (Check only one)  1 Certifying 2 Medical E	Hospital: 1 Inpatie  28a. Date of Injur (Month, Day  ation  t be led 28e. Place of Injur building, etc	nt 2 ER/Outpat ry , Year) 28b. Time , Injury ary - At home, farm, . (Specify) of my knowledge, defeamination and/or	tient 3 DOA Oth e of Worl y M 1 Street, factory, office	26 Place of Deer: 4 Nursing By yat Yes 2 No	24a. Was autop performent of the control of the con	an sy 24b. rmed? 2 No 24b. rmed? 2 No 24b. rmed? 2 No 24b. rmed? 2 No 24b. rmed 2 Now injury occur street and Number No. Street No. Street No.	3 ☐ Probab  Were autops: prior to comp death? 1 ☐ Yes 2  mer (Specify) red  per or Rural F  anner as stat and due to the	y findings available letion of cause of No  Route Number,  ed. le cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 221, 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** EONID. KARALNIK OCTOBER 15, 2009 12:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME PIKESVILLE BALTIMORE 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
UKRAINE Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 215-94-4020 80 01-15-1929 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ¥ Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4155 CREST HEIGHTS ROAD USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COBBLER SH0ES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GREGORY KARALNIK **ASTER** ပ္ STEPANKOVSKY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IDA KARALNIK/WIFE 4155 CREST HEIGHTS ROAD, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State E HEBREW 10-18-2009 | REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 21. Signature of Funeral Service Licensee Let 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause the line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23d. Date of delivery Month Day Year use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be Certification: To 6 ☐ Other (Specify) ury occurred

burial-tran physician at the burial P.O. Box 68760. attending p signed by the a Division of Vital Records, cate has t page 2 s or Attending Physician: The certificate this

After th funeral within 24 hours after death

To the Funeral Director:
completely filled in by the f

**Funeral** 

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it is it edien Examinar must be notified at

72 hours after

12 should be filed wi h and Mental Hygier 7 is marked other th

Health a

permit. Pages 1.
Department of Hee Important: If item any injur-

**Physician** 

/Medical

Examiner

item 27 other to

Baltimore, Maryland 21215-0036

`	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  23c. If yes, outcome of pregnancy 3 ☐ Ectopic pre		23d. Date of delivery Month Day Yea
Part II. Other significant condition	contributing to death but not resulting in the underlying car	use given in Part I.	23e. Did tobacco use contribute to the cause of deal
- Debroso	col.		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unk
			24a. Was an autopsy findings ava prior to completion of caus death?  1 Yes 2 0 10 1 1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Hon	ne 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  M	c. Injury at 2 Work? 1 □Yes 2 □No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		office 2	8f. Location (Street and Number or Rural Route Number City or Town, State)
29a. Certifier 1 rtifying	Physician: To the best of my knowledge, death occurred a	t the time, date and place, a	and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) cause of death (Item 23a) (Type, F

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated

2 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-			<b>27,28a-f</b> Ge	artment of He fer me, g89 rtificate of De	<b>6','10716'/</b> eath	Be ARP 60	eg. No.2 0 0	9 3348
Physician	,	1. Decedent's Name (First, Middle, Las	1)				2. Date of Death Month		3. Time of Death
Medica		Richard Lewis K					Octuber	05 20	
Examine	r	4a. Facility Name (if not institution, give	•		4b. City, Town, or Le	ocation of Death		4c. County of	Death
		Washington Coun  5. Social Security Number 6. Se		(In yrs. last birthday)	Hagers If Under 1 Year		8. Date of Birth		ngton J. Birthplace (State or Foreign
Funeral Director			7	82 Yrs.		Hours Min.	May 4,	Year) 1927 M	Country) [aryland
at at	5	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
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the n		10e. Street and Number			10f. Zip Code	·	10	0g. Citizen of Wha	at Country?
s 23a	Funeral	107 Stouffer Ave	nue		21740			USA	
o in	۾	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 \( \overline{\text{N}} \) Yes 2 \( \overline{\text{N}} \) N If Yes, Give Year or Dates.	10	Was Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2【】No	Mexican, Puerto	cify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc. White
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h and Mental I	ŀ	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b Mailir	ng Address (Street and			City or Town State	e. Zip Codel
alth a 27 is r tra		Ravenna Kline/spor	ıse		Stouffer A				1740
popartment of Healt Important: If item 2 any injury or other once,		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify		20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	C	Date 2	20c. Location - Cit	ty or Town, State
Departr Imports any inju		21. Signatur of Funeral ervice Licens	Jave, Dire		lare and Address altimore, l	•		Baltimor	e Street
Medical the purial-transit the burial-transit the burial-transit the burial-transit the burial Examines	edical Examiner	disease or condition resulting in death)  Sequentially list conditions, if anv. leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a b.  Due to (or as a c.	consequence of):  consequence of):  consequence of):		ERTIFICATION APP	ROVED BY MEDICA	L EXAMINER	
ne attending ad for use as	ĚΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No g Unknown	23c. If yes, outcome o  1  Live Birth 2  4  Pregnant at	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	,
Id be deta	≥	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause given	in Part I.			te to the cause of death?
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ector,	å l	25. Was case referred to medical examiner?	lospital:			e of Death (Check	only one)		
this dir	<u>∘</u>	1 X Yes 2 No 27. Manner of Death	1 Inpatier 28a. Date of injury	t 2 ER/Outpatier				ice 6 Other (S	Specify)
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n 24 hours le Funeral pleted filled	Medical	29a. Certifier (Check 2 Medical Examin	ier: On the basis of exa	ny knowledge, death o	occured at the time, da	death occurred at	the time, date and	place, and due to	the cause(s) and manner stat
		29b. Signature and title of certifier		,	29c. License nu			d. Date signed (M	
Voithit comp.	ı								1
within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.			The		00000	-994		10/5	12009
withii To th comp	4	30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Type, F	1110 Me	7974 dical	Cama	10/5/ s Rd. F	12009 Hugerstünzi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 25.1, 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 1245 PM ilcoyne october award 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baitimore City Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F 59 Yrs 1949 Pennsylvania 217-50-4130 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1610 Pinnter Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Fire Department Firefighter yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Kilcoyne Iris Margaret Willett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marylu S. Kilcoyne (Wife) 1610 Pinnter Road, Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Green Mount Crematory 10/21/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign: be of Funeral Struct Ucensee

Martin U. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? rcellire 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Failure Liver 24a. Was an autopsy performe organ system 1 □Yes 2 🖾 No

Physician /Medical Examiner

physician and s the burial-transi

attending pl

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has

After this

To the Hospital C. within 24 hours after death.

To the Funeral Director: Aft

that the death certificate be executed

The law requires

Box 68760

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of Vital Records,

Division or Attending Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

**Physician** 

/Medical

**Examiner** 

Director

Funeral

2

Completed

Be

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Experiment.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart

Multiple 25. Was case referred to medical

examiner?

27. Manner of Death

29a. Certifie

1 ☐ Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

RES-000

30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Boutimore, MD, George

State Registra

31. Date filed (Month, Day, Year) OCT 2 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #6&7 Per FH G896 10/20/09 III
State of Maryland / Department of Health and Mental Hygiene Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year assandre 10 2009 01:41 /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death emoria Age (IDyrs. last birthday) 6. Sex If Under 24 Hrs. 1973 8. Date of Birth (Month, Day, Birthplace (State or Foreign Gountry) **Funeral** Months Days Hours Min -14-560 8 1 ☐ M 2 🗹 F 35 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 202 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Adical Examinar must be multified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married \$ 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2Creto Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ဂ Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)# 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlal 2 € Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses au wulon 23a. Part 1. Enter the disease, or complications that caused by death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASTHMA EXACERBATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the irector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 🐧 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 □ No 1 XYes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∭ Yes 2 No Certification: To 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deatle Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID AT 2438946 B6 10, 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANICE UNION HEHIORIAL 31. Date filed (Month, Day, Year) Registrar's Signature State 20 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month AYTON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne <u>Arund</u>el 7. Age (In yrs, last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Country) Illinois **Funeral** 324-03-1239 Months 94 Director Usual Residence of Decedent 28a-f shov 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Tower Road 21146 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Yes 2 X No Yes, Give Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked on any injury or other traumatic eve ၉ Harold Layton Myrtle Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aileen Russell Layton/Wife 3 Tower Road, Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Ardent Cremation Services 1 Burial 2 X Cremation 3 Removal from State 10/20/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licenses M01197 Laura C. Hardesty 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Physician/ resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE f yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ No g ☐ Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed 2 - No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation M 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cartific completed cause of death (Item 23a) (Type, Print) ANNAPOLIS MAZIYO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

68760

Box (

Records,

**Division of Vital** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Alfred W. Lyons Jr. 2009 9:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9 Carvel Circle Edgewater Anne Arundel 5. Social Security Number 6. Sex 1X M 2 □ F If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth Date of Day, Year) (Month, Day, Year) 1941 9. Birthplace (State or Foreign **Funeral** Birthpia Country) Maine Months Days Hours Min 219-38-9535 Director 68 May Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🎇 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Carvel Circle USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Xyes 2 No 1960 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 1965 White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic. Alfred W, Lyons Sr Marv Grimaldi traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Lyons, Son 10920 Baskerville Road Reisterstown, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Metro Crematory Inc. 10/19/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor R. Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Duelto as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? After this certificate | 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital 2 No Other: ဂ္ 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖫 🎖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Name and address of person who completed ca death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

09-07321
Timothy Leisey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Cert	tificate of	Death			Reg. No.	
Physic Medical Exam		1. Decedent's Name (First, Midd Timothy		eisey	-			2. Date of Do Month Septem		3. Time of Death 1740 hrs
		4a. Facility Name (if not instituted 1741 Covington Street		nber)	4	o. City, Town, or L Baltimore	ocation of De		4c. County of	of Death
Funeral Director		5. Social Security Number 216–11–8657	6. Sex 7	'. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Birth (MM/DD/YYYY 29/69	9. Birthplace (State or Foreign MD Country)
nd how any <u>Cc.</u>	_	Usual Residence of Decedent  10a. State 10b. County  MD 1	N/A	10c. City, 7	Town or Location	n timore C:	ity			10d. Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho	Director	10e. Street and Number 1741 Covingto	on Street			10f. Zip Code	2123	0	10g. Citizen of Wh	
death or iten	Funeral	11. Marital Status 1 Never Married 2	larried Armed For	dent Ever in U.S ces? 2 X No	If Ye	Decedent of Hisp s, specify Cuban,	Mexican, Pu		White	- American Indian, Black, e, etc. white
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygier, than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	leted by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1-4		16a. Decedent' during mo	Yes 2X No s Usual Occupation st of working life. I	n (Give kind OO NOT use		Specify:	siness/Industry
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altimore, MD 2 mit. Pages 1 and 2 shou partment of Health and N portant: If item 27 is n ury or other traumatic		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other S	_	n State Gle	lace of Disposit ematory or othe n Haver	ion (Name of cemer place)  1 Cemeter	etery,	Date 9/23/200		City or Town, State
Balt permit. Depart Import		21. Signature of Funeral Service	Licensee VICEC	2700	rda (2. Na Chan 150	nne and Address of Les L. S	f Facility teven t Ave	s Funera , Baltim	l Home, l nore MD'2	Inc. 1230
Physician /Medical xaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <b>Hypert</b> e	nsive c	ardiova				arrest, shock, or hea	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c							
ated nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):	•		***			
8760, ifficate be executed ng physician and st the burial - transi	n/Medical	X UNPENDED  IF FEMALE:	TIMENDED	23a,PII		mE, g897	11/5	/09 TT	22d Date of	deline
Box 68760, e death certificate be the attending physic ed for use as the bur	sicia	23b. Was decedent pregnant in the past 12 months?	ne 1 Live bir	th nt at time of deat	2 Feta	al death 3	Ectopic pre	gnancy	23d. Date of Month	Day Year
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Vital Records, systian: The law require this certificate has been sidilector, page 2 should be	Completed							per	topsy proformed? c	Vere autopsy findings available brior to completion of cause of death?  Yes 2 No
n of ing Pl	To Be	25. Was case referred to medica examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 X Natural 5 Pend	Hospital: 1 Inp		ER/Outpatient 28b. Time of Inj	3 DOA Oury 28c. Injury	ther <sub>4</sub> Nu	eck only one) ersing Home 5 28d. Describ	Residence 6 N	
Division  To the Hospital or Attendia within 24 hours after death.  To the Funeral Director: A completely filled in by the fun	Sertification:	3 Suicide 6 Coul	d not be rmined (Specify)	of Injury - At hon	ne, farm, street	, factory, office bu		28f. Location or Town		er or Rural Route Number, City
To the Hosp within 24 ho To the Func completely f	Medical C	one) 2 Medical Exa	hysician: To the best of miner:On the basis of and manner sta	examination and		on, in my opinion, o	death occurre			
		29b. Signature and title of certified	my Me	of death (term 2	125	29c. License O.C.M			29d. Date sign	ed (Month, Day Year) 19, 2009
ØV		Melissa Brassell, MD	Assistant Medi	cal Examine	er 111 Pe	enn Street, Ba	Itimore, N	1D 21201		
St Regist		31. Date filed (Month, Day, Year)	2009 32. Begi	istrar's Signature	1. Span	les .				
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		1 - For State Registrar	State c	of Marylar	-	artment of F rtificate of	lealth and N Death		ene of S	33487
		Decedent's Name (First, Middle, I	Last)					2. Date of Death		3. Time of Death
Physic Med		YVONNE	A.		ELACE			OCT /	Day 2009	2.20 AM
Exam	iner	4a. Facility Name (If not institution, g					r Location of Death		4c. County of Dear	th
Funera		Good Samarit  5. Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	timore If Under 24 Hrs.	8. Date of Birth (Month, Day,	n/a	thplace (State or Foreign
Directo	_	217-70-0407	1□ M 2□ F	5	O Yrs.	Months Days	Hours Min.	March ]		MD
and w		Usual Residence of Decedent  10a, State 10b, County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
Maryla f sho	Ď	MD								1 □Xes 2 □ No
r 28a	Director	10e. Street and Number			Balti	10f. Zip Code		10	g. Citizen of What Co	untry?
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tems	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13. V	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
illed within 72 hours after death with the Maryland Hygiene. Hygiene.  ther than "natural", or items 23a or 28a-f show ent, transcribed by rocified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes If Yes, Gi Year or D	ve	,	I∐Yes 2∭2No	Specify:		Specify:	Black
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should and Me	은	19a. Informant's Name/Relationship			19b. Mailin	g Address (Street	and Number or Rui		City or Town, State, 2	
and 2 salth a		George Bumbra	y/ Son		1227	Woodbo	urne Ave	e. Balto	Md 2123	39
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t. Pag rtmen rtant:		4 □ Donation 5 □ Other (Spec	cify)	Gr				:19,20ps	Balto.	, Md
permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lic	ensee	-	C		B. SCRUG		RAL HOME	
		23a. Part 1. Enter the disease, or co	mplications that o	aused the deat		L412 E. er the mode of dyir	PRESTON ng, such as cardiac		LTO MD	21213 Approximate
Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on e		ECPIA	ATORY	ALLTRI	= ( ( ( )	NDROM	Interval Between Onset and Death
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certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregna	ancy				23d. Date of de	livery
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death death ctor: /	cati	2 Accident investigati 3 Suicide 6 Could not	be 200 Blace	of Injury At he	omo form etro	M 1 □	Yes 2 □No	20f Location (Class	and and Missahas as D	und Davida Normhau
al or A s after I Direct	Certification:	4 ☐ Homicide determine	d buildi	ing, etc. (Specif	y)	et, ractory, office		City or Town,	et and Number or Ri State)	urai Houte Number,
lospita Hours unera		29a. Certifier 1 Certifying I	Physician: To the	best of my kno	wledge, death	occurred at the ti	me, date and place	, and due to the ca	use(s) and manner a e and place, and due	s stated.
To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one)	and man	ner stated.	on ana/or ith	29c. Licens				
<b>5</b>		29b. Signature and title of certifier	n n	D.		_			Date signed (Mont +4)	
A.1		30. Name and address of person wh	o completed caus	se of death (Iten	n 23a) (Type. F	Print)				2009.
カマ			A21, S	2601 L	OCH RI	AVEN B	LVD BA	ALTIMOR	RE 2123	9 MD.
St	ate	31. Date filed (Month, Day, Year)		legistrar's Signa	ture					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

B. Lawson  At Pointy Name of col institution, pare area and number)  At Pointy Name of col institution, pare area and number)  At Pointy Name of col institution, pare area and number)  At Pointy Name of col institution, pare area and number)  At Pointy Name of color of the colo			1 - For State Registrar  1. Decedent's Name (First, Middle, L			rtificate of Death	, ,	eg. No.	0013
4. Profile year of the controlled power and another of the control				,	T.awson		Month 1 3	2009 Year	
Second   Process   Second   Process   Second   Process   Second   Process   Second   Process   Second   Process   Second   Seco						4b. City Town or Location of Death			
Social Security    Social Security   Social Secu	Exami		911 Pennslyva	nia Ave.	Apt.2B				
Joseph   J	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		
Top   State   Top   To	Director		220-34-6021	1 L M 2 1 F	58 Yrs.	Months Days Hours Min.	Oct.20	,1950	Md
23a. Part 1. Enter the disease, or complications that-claused the death. Do not enter the mode of dying, such as card ac or respiratory arrest, indexed course from the disease, or complications that clause. It is derived in the course of a course of the course of th	72 hous allet dealh with the Maryland hatural", or items 23a or 28a-f show dical Examinar must be notified at	_			10c. City, Town or Lo	ocation			10d. Inside City Limits
23a. Part 1. Enter the disease, or complications that-claused the death. Do not enter the mode of dying, such as card ac or respiratory arrest, indexed course from the disease, or complications that clause. It is derived in the course of a course of the course of th	Ba-fs	cto	MD n/	a	Baltin	more			Yes 2□No
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23a. Part 1. Enter the disease, or complications that-claused the death. Do not enter the mode of dying, such as card ac or respiratory arrest, indexed course from the disease, or complications that clause. It is derived in the course of a course of the course of th	iene. than "	dmc	Elementary/Secondary (0-12)		)+)		I	Social S	ecurity
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23a. Part 1. Enter the disease, or complications that-claused the death. Do not enter the mode of dying, such as card ac or respiratory arrest, indexed course from the disease, or complications that clause. It is derived in the course of a course of the course of th	it if		Magazial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	1 .		1 2000	Balto,	Md.
23a. Part 1. Enter the disease, or complications that-claused the death. Do not enter the mode of dying, such as card ac or respiratory arrest, indexed course from the disease, or complications that clause. It is derived in the course of a course of the course of th	partr Sorta / inju	Hi			22	. Name and Address of Facility	1,2009		
23a. Part L. Enter the disease, or completed forms that "Blued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, encock, not here failure. List only one cause or each. Due to first a consequence of):	Departri Importa any inju once.		12 17	2	9	CALVIN B. SCRUG 1412 E. PRESTON	GS FUNI I ST. BA	ERAL HOM	E 21213
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes, outcome of pregnancy   1   1   23c. If yes, outcome of pregnancy   1   1   23c. If yes, outcome of pregnancy   1   1   23c. If yes, outcome of pregnancy   1   1   23c. If yes, outcome of pregnancy   1   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of death?   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy   1   23c. If yes, outcome of the pregnancy	as been signed by the attending physician and 2 should be detached for use as the burial-transit	al Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	с					
236. Did lobacco use contribute to the cause of death?   236. Did lobacco use contribute to complete on the cause of death?   236. Did lobacco use contribute to complete on the cause of death?   236. Did lobacco use contribute to complete on the cause of death?   236. Did lobacco use contribute to complete on the cause of death?   2	attending for use a		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3				•
25. Was case referred edical prior to completion of cause of death?  26. Place of Death (Check only one)  27. Was an autopsy informing availance of cause of death?  28. Date of Injury  2	igne be d	þ			ut not resulting in the un	nderlying cause given in Part I.			
25. Was case referred edical prior to completion of cause of death?  26. Place of Death (Check only one)  27. Was an autopsy informing availance of cause of death?  28. Date of Injury  2	been	ete		8					
25. Was case referred edical examiner?  1   Yes   No   Hospital:   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6   Other (Specify)    27. Mann   of Death   1   Netural   5   Pending investigation   3   Suicide   4   Homicide   6   Could not be determined   28e. Place of Injury   At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)    29a. Certifier   Check only one)   28f. Location (Street and Number or Rural Route Number, City or Town, State)    29a. Certifier   Check only one)   28f. Location (Street and Number or Rural Route Number, City or Town, State)    29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)    30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   31. Date filed (Month, Day, Year)   32. Degistrar's Signature	# CI I	ошо					autopsy performe	ed? prior to death?	completion of cause of
The state   The	tifica tor, p	a	25. Was case referred per edical			26. Place of Docti			s 2□No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AYE Lucia. n.D. 5010. Yorkit Rt. Bulto. ng. 21212.  State  31. Date filed (Month, Day, Year)  32. Degistrar's Signature	is cel			Hospital: 1 Inpatie	nt 2 □ FB/Outpatien	Othori			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AYE Lucia. n.D. 5010. Yorkit Rt. Bulto. ng. 21212.  State  31. Date filed (Month, Day, Year)  32. Degistrar's Signature	ter th	١							эспу)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AYE Lucia. n.D. 5010. Yorkit Rt. Bulto. ng. 21212.  State  31. Date filed (Month, Day, Year)  32. Degistrar's Signature	Director	ertific		28e. Place of Inju	ry - At home, farm, stre (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AYE Lucia. n.D. 5010. Yorkit Rt. Bulto. ng. 21212.  State  31. Date filed (Month, Day, Year)  32. Degistrar's Signature	24 nours e Funeral tetely filler		Check only 2 Medical Exal	miner: On the basis of	examination and/or inv	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the car red at the time, dat	use(s) and manner a re and place, and du	ns stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AYE Lucia. n.D. 5010. Yorkit Rt. Bulto. ng. 21212.  State  31. Date filed (Month, Day, Year)  32. Degistrar's Signature	To the	Me	29b. Signature and title of certifier	statistics sta			290	d. Datę signed (Mon	th, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature			M.D.	•		028266.			,
State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature	V		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, F	Balto. ng. 213	112.		
Registrar OCT 9 0 2009 A	Stat	е	31. Date filed (Month, Day, Year)	32. Degistra		V -			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 17,2009 12009 2009 Physician RUTH 11:25P M LEVI MARJORIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Presbyterian Home of Maryland Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Mar Ch Day 4 Year) 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 XX 94 384-26-9842 Michigan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 XNo Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court 21204 USA

1 □Yes 2XXNo

Homemaker

20b. Place of Disposition (Name of cemetery, crematory or other place)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GreenMount Crematory Oct 20, 2009

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

Unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3929 Cloverhill Road Baltimore , Maryland 21218

14. Race - American Indian,

White

Herrick

Black, White, etc

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

16b. Kind of Business/Industry

Own Home

20c. Location - City or Town, State

By Huse

4104

Sa.Je

Baltimore, Maryland

12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 XX

If Yes, Give Year or Dates:

College (1-4or 5+)

DTR

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other than that any injury or other traumatic event, Ira I wallock Examinar mast be notified at Baltimore, Maryland 21215-0036

**Funeral** 

Director

Funeral

Completed by

Be

2

Examine

by Physician/Medical

Be Completed

Certification: To

Medical

State Registrar Kenneth

11. Marital Status

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

1/□ Burial 2 KK remation 3 □ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

XX Widowed 4 Divorced

17. Father's Name (First, Middle, Last)

Linda Tanton

20a. Method of Disposition

Arthur Everet Ikens

19a. Informant's Name/Relationship (Type. Print)

☐ Donation 5 ☐ Other (Specify)

2 Unature of Funer 200 ce licens

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar the attending physician and 101 icate has been signed by the ; page 2 should be detached within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760

2 Funature of Funer Syce licer	New Couches 22. Nat	ne and Address of Fa <b>Mil</b> ytch 6500 York Roa						
23a. Part 1. Enter the disease, of com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y	Approximate Interval Between Onset and Death						
Sequentially list conditions, if any, leading to immediate Cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):							
	d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 254No 9 ☐ Unknown	23d. Date of del Month	delivery Day Year						
Part II. Other significant conditions o	ontributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did tobacc		the cause of death?			
25. Was case referred to medical			24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of 2			
examiner?	26. Place of Death (Check only one)  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4≅Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)							
27. Manner of Death 1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury N	28c. Injury at Work?	ome 5 ☐ Residence 28d. Describe how in	cify)				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined				and Number or Rural Route Number, ate)				
29a. Certifier  (Check only one)  Check only one)	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place pation, in my opinion, death occu	e, and due to the cause rred at the time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)			
29b. Signature and title of certifier	- m, D.	29c. License number	29d. [	Date signed (Month	h, Day, Year)			

, Charles St.

6701 N

32. Registrar's Sinature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend # 8 per FH 9896 10/21/09 TT/ Item#10e, IsperFH, G896, 10/29/09, WS
amend #19b Per Int G896 10/21/09 Health and Mental Hygiene

Certificate of Death

Reg. No. 2000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2009 9:42 Robert Glin McDonald 17, October 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Months Days Hours 1 **X**M 2□ F 76 417-38-7628 9/14/1933 Mississippi Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No MD Clarksburg Montgomery 10e. Street and Number edmont 10f. Zip Code 10g. Citizen of What Country? 12305 20871 USA Road 12. Was Decedent Ever in U.S. Armed Forces? 1 இYes 2 □ No IfYes, Give Year or Dates: US Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White 1 □Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DC Transit System Electronic Technician 12 18. Mother's Namber (Middle), Maiden Surname) 17 Father's Name (First, Middle, Last) David Arnold McDonald Dora - Deerman 19b. Mailing Address (Street and Number or **Clarokebureg** City or Town, State, Zip Code) 12305 Piedmont Road, <del>Claksville</del>, MD 20871 19a. Informant's Name/Relationship (Type. Print)
Nina McDonald / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 10/19/2009 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services PO Box 1431, Baltimore, MD 21203 vsla 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic Shock Due to (or as a consequence of):

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

the

with

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

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d other than "natural", or items 23a or 28a-f st event, the Madical Examinar must be notified

and Mental Hygiene. is marked other than

traumatic

Department of Health a Important: If item 27 is any Injury or other traconce.

Pages 1

sician and burial-transit executed attending physician for use as the buria þe signed by the a icate has been siç , page 2 should b director, this funeral After To the Hospital or Attending within 24 hours after death. To the Funeral Director: A filled in

Physician/Medical

Be Completed by

Certification: To

Medical

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cerebral Vascular Accidents, M Due to (or as a consequence of):  c. Parkinson's Disease, Progressi Due to (or as a consequence of):  d. Pneumonia	-			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year		
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?		
Clostridium Di	ifficle Kryphoscoliosis	1 ☐ Yes 2	□ No 3 □ Probably 4X Unknown		
Respitarory In	nsufficiency	24a. Was an autopsy performed? 1 □ Yes 2 🖾 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)			
1 Yes 2 No	Hospital: A Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	6 ☐ Other (Specify)			
27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 \( \text{Yes} \) 2 \( \text{No} \)				
3 □ Suicide 6 □ Could not b 4 □ Homicide determined		3f. Location (Street and Number or Rural Route Number, City or Town, State)			
	hysiclan: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre				

29c. License number

MD D55054

604 S. Frederick AveSte. 409, Gaithersburg, MD 20877

29d. Date signed (Month, Day, Year)

State Registrar

Attan Kasid, 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2. Registrar's Signature

anou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4aperPHYS, G896, 10720709, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death October Physician Vempsey McManus Margaret 8:28 AM 2009 /Medical 4a. Facility Name of hot institution, give street and number) 4c. County of Death Examiner Minkton MI Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2√2 F 89 217-18-3476 Director Maryland April18,1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Monkton 1 ☐ Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21111 2805 Shepperd Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No white Specify: Specify: 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) elcuision Syndicated TV Columnist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Thoman Edwin Abell Dempsey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2805 Shepperd Road-Monkton, Maryland 21111 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Mary Guba-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bellefield Green Oct.19,2009 Monkton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Evans Funeral Chapel and Cremation Services Landrae LTME Foods 16924 York Road-Monkton, Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Division 1 Natural
2 Accident 5 Pending investigation ours after death. leral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) October 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

N. WOHO

31. Date filed (Month, Day,

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Halsted

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death · <sup>Day</sup> 6, 2009 October 8:30 P M Donald Raymond McCausland 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Genesis Loch Raven Center Baltimore Baltimore 8. Date of Birth (Month, Day, Year) Sept. 7, 1926 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land . Age (In vrs. last birthday) 1 X M 2 □ F Months: Days Hours Min. 83 214-22-5790 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Parkville Baltimore 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 9617 Oak Summit Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ₩Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 ☑ No Specify: white Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BG&E Customer Relations 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene McCausland Beatrice May Eason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9617 Oak Summit Avenue-Parkville, Maryland 21234 Caroline McCausland-spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. 21, 2009 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services LTY 12 tudo 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the eath shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 9 Unknown partibuting to death but not resulting in the proterlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 🛛 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other:

**Physician** /Medical Examiner

Physician

Examiner

Director

Funeral

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Completed

Be

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MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinal must be notified at once.

3altimore, Maryland 21215-0036

/Medical

burial-transi and physician at the burial attending properties for use as use signed by the a

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

the Hospital

certificate

Exami Physician/Medical þ Completed

cate has b page 2 s Be ၉ After this funeral of Certification: al or Attending F s after death. I Director: After d in by the funera

IF FEMALE 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown

Hospital:

6 ☐ Could not be

1 Inpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

111 Rockville &

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

ical

30. Name and address of pereon who completed cause of death (Item 23a) (Type, Print) 13 LITUH 2 Hua

31. Date filed (Month, Day, Year)

Registrar's Signature

and manner stated

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day 8 **Physician** 2009 RAMICES MCDADE 7.40 A M DCT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE WASHINGTON MED CTR ANNE ARUNDEL FLEIN BURNIE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Wonths | Days | Hours | Min. | 7 - 27 - 1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😾 F 217-20-8589 83 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: if item 22 or 28a-f show amportant: if item 27 is marked other than "natural", or items 23a or 28a-f show amp Injury or other traumatic event, the Medical Examination and once. MD Anne Arundel Millersville 1 ☐ Yes 2 🕅 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21108 USA 504 Brightview Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify white þ Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agnes Carroll Earle A. Murphy ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Luann F. Miller/daughter 504 Brightview Drive, Millersville MD 21108 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 10/20/2009 Metro Crematory Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 21. Signature of Funeral Service Licensee 421 Crain Hwy SE Glen Burnie MD 21061 M01364 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ENCEPHALOPATH **Physician** LYAU ANOXIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TOAR MEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 🐉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 2140 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred **Division** Natural 5 ☐ Pending investigation ours after death.
neral Director: A
filled in by the fu 1 🗆 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier procentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEORGE

BONNE. 32 Registrar's Signatur

comme mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 HOSPITAL DR FLETI BURNUF

29c. License number

0059190

2009

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

33494

		-	For State Registrar	State of Ma		epartm Certifica			and M	lental Hy	giene Reg. No.		
Phys			1. Decedent's Name (First, Middle, Last) Beulah Mae Martin	•						2. Date of De		2,009	3. Time of Death
	edica mine							Location o	f Death	<u> </u>	4c. Co	unty of Death hingtor	
Fune Direc			5. Social Security Number  212-74-3113  Usual Residence of Decedent		(In yrs. last birthd 2 Yr	Mont	der 1 Year Is Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir May 22	th <sup>1y, Y</sup> 1937	9. Birthp Coun	olace (State or Foreign try) UNK
<b>DEJITIMOTE, IMARY/IGING 21213-UU30</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any iniux or other traumatic event. the Medical Examiner must be notified at	once.	To Be Completed by Funeral Director	10a, State 10b. County MD Washingto: 10e. Street and Number 12 S. Walnut Stree	t; #204  2. Was Decedent Event Armed Forces? 1	16a, D (G lift)	OWN  10f. 2 : 13. Was Dee If Yes, s  1 □ Yes eccedent's Usive kind of te. DO NOT  Mailing Addres 76; isposition (terematory company)	2 S No 2 S No sual Occupation done disse retired)  ess (Street a Brandy lame of rother place	n, Mexican, Specify: stion Un uring most  18. Mother Inez and Number wine	k of workir r's Name Mar r or Rural D	(First, Middle, ie Huds Route Numbe st Virs	USA  14.  Spe  16b. Kind  Maiden Surre  Son  ir, City or Tow  ginia  20c. Locate	Race - Americ Black, White, ecify: Whit of Business Inc	an Indian, etc. ee dustry unk
that the death certificate be executed that the death certificate be executed med by the attending physician and edetached for use as the burial-transit		by Physician/	23a. Part 1. Enter the disease, or combinishock, or heart failure. List only one shock, or heart failure. List only one shock, or heart failure. List only one shock of the sh	Due to (or as a of the control of th	consequence of):  and the consequence of):  pregnancy  Fetal death ime of death	intest	c pregnancy	lace	Lin	23e. Did t	23d	contribute to th	Day Year e cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Modinal Cadificator To De Complete	medical certificate: 10 b	27. Manner of Death  1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined  29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 Certifying Nurse  29b. Signature and title of certifier	28a. Date of injury (Month, Day, 1) 28e. Place of Injury building, etc. (ian: To the best of mr. On the basis of exa Practioner: To the best of the be	r - At home, farm, (Specify) y knowledge, des mination and/or in est of my knowled	e of ry M street, fact ath occured vestigation, ge, death oc	28c. Injury work? 1 0 ory, office  at the time, n my opinior curred at the	date and p n, death occ time, date number	No 2 lace, and curred at t and place	24a. Was auto performent of the carbon (see the carbon (see the carbon (see the carbon due to the carb	an osy ormed? 2 No dence 6 on own injury occurrent and Nurn, State) use(s) and mund place, and e cause(s) and 29d. Date significant of the signifi	4b. Were autoprior to cordeath?  1 Yes  Other (Specify)  curred	Route Number, d. se(s) and manner stated. ted.
S Regi	State strar		31. Date filed (Month, Day, Year) 0CT 2 0 2009	alka	s Signature	251	Ras	ST P	tntz	etam	St. t	tuges:	town, m

Amend 20b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. PerFh g896 10/20/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER SEENA ROTHSTEIN 2009 MURRAY 6:00 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 1 / 21 / 31 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months 214-26-8557 78 Yrs Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified Director MD BALTIMORF 1 ☐ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4204 OLD MILFORD MILL ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ev Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married ō 1 ☐ Yes 2 🔏 No \$ Specify Specify: WHITF "natural", 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than " any injury or other traumatic event, Ins. Mo. Elementary/Secondary (0-12) College (1-4or 5+) **TEACHER** EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IRVING ROTHSTEIN MOLLIE 2 BLUEWEISS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINDY FISHER / DAUGHTER 4423 SUMMER GRAPE ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State AN centery remains of other place)

AN CENTER FOR THE MOSES 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) CHAIM Montefiore 10/18/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not exter the mixe of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line. v arrest. Approximate Interval Between Language and Party Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Day Month Year 5 ☐ Other (specify) 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 🗂 No 3 ☐ Probably 4 ☐ Unknown Completed 1 □ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending I Director: 2 Accident investigation 1 ☐ Yes 2 No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af e Funeral D etely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 1 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of perleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **MENDEL SOHN** MAX 20ŎŦ OCTOBER 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 【 M 2 🗆 F Days Hours Country 213-30-4133 0577671933 76 Yrs. Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 □ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2313 SUGARCONE ROAD 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 (A Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) EXECUTIVE PHARMACEUTICALS other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked cany Injurior or other traumatic eve 0 ISRAEL MENDELSOHN ROSE SILVERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA MENDELSOHN / WIFE 2313 SUGARCONE ROAD, BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State BETH EL MEMORIAL PARKNO/19/2009 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Universitying Cause (Disease or linjury Due to (or as a consequence of) ѷ that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician ned for use as the bunal Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Unknown that the signed by t d be detach o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No The 2 🗷 No 1 🗌 Yes Physician: Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) 2 No Hospital: Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural Hospital or Attending Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Coage Hennowing 00059479 10/17/69 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)\_ Towson town blud, Towson, MD 21204 Honnawii MA 555W. 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician/ cal Examine Funeral Director		For State	Cert	tificate of De	ath	Reg.	No.	
Funeral	/   '	egistrar . Decedent's Name (First, Middle,Last)				2. Date of Death	av Year	3. Time of Death
		Marcia		Martin	<u> </u>	October 12,	2009	1808 hrs
	4	a. Facility Name (if not institution, give stre			y, Town, or Location of De	eath	4c. County of Deat	n
	L	Johns Hopkins Bayview Medic			Itimore	ii. In Data of Direct	m/a MM/DD/YYYY) g. Bi	
Director		5. Social Security Number 6. Sex	7. Age (In yrs. la		Inder 1 Year If Under 24	Min	Forei	gn
	2	217-58-5543 1 <sub>M</sub>	2x F 54	Yrs.		Nov.12	,1954	ountry) MD
	_	Jsual Residence of Decedent	40e Citu	Town or Location				10d. Inside City Limits
w any		0a. State 10b. County	-					1 XYes 2 No
Aaryland 28a-f show I at once.	ΞL	MD n/a	Ba	altimore		I 10a	Citizen of What Cou	
the Maryland a or 28a-f sh tifled at once	ברי ברי	0e. Street and Number		101.	Zip Code	Tog.		and y :
3, MID 616 13-10-00-00 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland tem 27 is marked bytene traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	<u> </u>	4213 Sheldon A			21206	10 % N N -	USA	rican Indian, Black,
r death with or items 23. must be no	<u> </u>	11. Marital Status 1 Never Married 2 Married	. Was Decedent Ever in U.S Armed Forces?		edent of Hispanic Origin? ecify Cuban, Mexican, Pu		White, etc.	ncan Indian, black,
or ite		1			0 N		Sansific D.1	n orle
ral",		3 Widowed 4 X Divorced If Ye or D	Dates:		2 No specify:	of work done	Specify: Bla	
hour Exan	g   -	15. Decedent's Education (Specify only hi  Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	working life. DO NOT use	e retired)		,
be filed within 72 be filed within 72 be filed within 72 beta fixed other than 'ent, the Medical Ba Complet		Elementary/Secondary (0-12)	2years	X Ray	echnician	ե	ohn Hop	kins Hospi
led within 72 Hygiene. other than the Medical	Сошріете	17. Father's Name (First, Middle, Last)	zycars		18.Mother's N	lame (First, Middle, Ma		
Filed Hy ed of the control of the co	a n	John Martin				ma Harris		
d Ment d Ment is mark tic ever		19a. Informant's Name/Relationship (Type,	Print )	19b. Mailing Add	ress (Street and Numbe			te, Zip Code)
ed 2 shoulth and m 27 is a	-1	Erin Hanson/Day		7110 M	Clean Bly	d Baltim	ore. Mđ	21234
and 2 fealth tem 2	1	20a. Method of Disposition	20b. F	Place of Disposition	(Name of cemetery,	Date 2	20c. Location - City o	or Town, State
Pages 1 lent of F unt: If i	- 1	1 Burial 2 Cremation 3 F		crematory or other p	Crematory	Oat 15 20	100 Bal+	o MD
Definition of the post of the portant: If ite injury or other to		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	GE					
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	1	21. Signature of Furieral Short Elicensee	<b>X</b>	ÇAJ	and Address of Facility	RUGGS FUN	IERAL HO	ME D 21213
	4	23a. Part I. Enter the disease, or complicat	ions that capsed the death	Do not enter the m	2 E. PRES	Iac or respiratory arres	BALTO M t, shock, or heart	Approximate Interval
hysician /Medical	I	failure. List only one cause on each li	ine.		, 0			Between Onset and Death
kaminer			hermal injur to (or as a consequence of					
	-	b	to (or as a consequence of	1).				
à	۱.	Sequentially list conditions, ——	to (or as a consequence of	f):				
	틹	cause. Enter Underlying Cause (Disease or injury that initiated						
Si si	Examiner	events resulting in death) Last Due	to (or as a consequence of	f):				
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ate be es hysiciar e burial	Medical						23d. Date of delive	200
ficate g phy s the t		IF FEMALE: 23b. Was decedent pregnant in the	3c. If yes, outcome of preg		eath 3 Ectopic p	regnancy	Month	Day Year
box box not the death certific the attending pred for use as the	sician	past 12 months?	Pregnant at time of de	noth	(Specify)	, - <u></u>		
death death I for 1	Š	1 Yes 2 V No 9 Unknown	Unknown	0.1.0.				
signed by the		Part II. Other significant conditions con	ntributing to death but not re	esulting in the unde	lying cause given in Part			to the cause of death?
es that t	2					1 Yes	2 V No 3 P	robably 4 Unknown
( in the state of	흵					24a. Was at		autopsy findings available o completion of cause of
	힑					autops:	ned? death	?
has been 2 should	ၟၟ႞					1 <b>✓</b> Yes 2	No 1 ✓	Yes 2 No
The law reicate has being page 2 shou	Be	25. Was case referred to medical examiner?	pital:	I spice is the	26.Place of Death (C		tesidence 6 Ot	hor:
cian: The law requires certificate has been sig	၂၉	1 100 2 110	oital: 1 Inpatient 2	ER/Outpatient 3  28b. Time of Injury			tesidence 6 Ot	
hysician: The law rec r this certificate has bee al director, page 2 shou		27. Manner of Death  1 Natural 5 Deading	28a. Date of Injury (Month, Day, Year)	260. Time of injury	1 Yes 2X N	1		in house fir
ling Physician: The law rec After this certificate has bee funeral director, page 2 shou		2X Accident Pending Investigation	9/30/09	11:30 pm				
Physician: ter this certi			28e. Place of Injury - At h	nome, farm, street, fa sidence	ctory, office building, etc.	or Town, St	reet and Number of ate) 4213 Sh	Rural Route Number, City eldon Ave
or Att		3 Suicide 6 Could not be	10. 10.	THETHE				
or Att	Certification:	4 Homicide determined	(0,000)					
Spital or Att hours after de meral Direct y filled in by	Certification	4 Homicide determined	To the best of my knowled	ige, death occurred	at the time, date and place	e, and due to the cause irred at the time, date a	(s) and manner as s	tated.
DIVISI sepital or Att hours after d meral Direct y filled in by	Certification	4 Homicide determined  29a. Certifier 1 Certifying Physician: one) 2 Medical Examiner: Or	To the best of my knowled	dge, death occurred and/or investigation,	in my opinion, death occu	e, and due to the cause irred at the time, date a	nd place, and due to	the cause(s)
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4a. Facility Name (If not institution, give street and number, The Johns Hopkins Hospital **Baltimore City** N/A8. Date of Birth (Month, Day, Year 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) Days Hours 1 X M 2 □ F 63 Dec 14, 1945 Alabama 421-60-4272 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 □ No N/A Maryland Baltimore City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 4121 Westview Road 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) University Elementary/Secondary (0-12) College (1-4 or 5+) Professor of English 5+ Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McCaffrey Hugh Leatrice Surratt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4121 Westview Drive, Baltimore, Maryland 21218 Janet A. Headley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 10/20/ 2009 Baltimore, Maryland 4 ☐ Other (Specify) 21. Signarité et Fineral Selvice (censee Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate

**Physician** /Medical Examiner

**Physician** /Medical

Examiner

10a. State

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Funeral

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Completed

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**Funeral** 

Director

items 23a or 28a-f show Examiner must be notified at

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"natural",

and Mental Hygiene. is marked other than

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician ar d by the at detached f s certificate has be director, page 2 sl within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	shock, or heart failure. List only	one cause on each line.	3,	,	Interval				
	Immediate Cause (Final disease or condition resulting in death)	_a. Hemowheel Snee4  Due to (or as a consequence of):			Onset a	nd Death			
lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ctopic pregnancy ther (specify)		23d. Date of delivery Month Day	Year			
ed by P	Part II. Other significant conditions	contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacc	ouse contribute to the cause				
Complete				24a. Was an autopsy performed?	24b. Were autopsy findir prior to completion death?	gs available of cause of			
Be (	25. Was case referred to medical		26. Place of Dea	ath (Check only one)					
10 B	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing H	fome 5 ☐ Residence	6 ☐ Other (Specify)				
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	ury occurred						
Medical Certification:	3 Suicide 6 Could not be determined		factory, office	28f. Location (Street City or Town, Star	and Number or Rural Route N e)	lumber,			
edical (	29a. Certifier 1	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and plac- tigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as stated. and place, and due to the cau	se(s)			
ž	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)				

RESO00

10/16/100

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Nayor

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 10/18/2009 Mary Nelson 3:00pm 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 321 Osborne Anenue Catonsville MD Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Day, Year 10/28/40 Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F Months Days Hours 68 203-30-4392 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 ☐Yes 🏞 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 321 Osborne Avenue 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No white Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Code Enforcer City Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Ryan Mary Witouski 19a. Informant's Name/Relationship (Type. Print) Natalie Ennis / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Osborne Avenue, Catonsville MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Jefferson Hills Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 【XRemoval from State 10/24/09 Jefferson Hills, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor Doda, Jr Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ONSIL 9 Wcer Due to (or as a consequence of): Sequentially list conditions, Due to for as a popularizance of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 ANo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No

**Physician** /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical

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Certification: To

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attending physician and for use as the burial-tran ed by the a been signed be should be deta certificate has b irector, page 2 sl

Box 68760,

P.O.

Division or Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed After this n 24 hours after death.

ne Funeral Director; At oletely filled in by the fu

within 24

State

Registrar

29b. Signature and title of certifier

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

5 Pending

investigation 6 Could not be determined

2 ER/Outpatient 3 DOA

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Warren 11:10 P<sup>M</sup> Howard 2009 Norris October 18, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 96 Driftway Cecil Earleville Birthplace Country) SD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 ★M 2 ☐ F 478-14-8294 87 Director 12/12/1921 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location show 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at NC Pinehurst Moore Director 1√2Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 200 Beulah Hill Road South 28374 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 "natural", or White ģ If Yes, Give Year or Dates: 1942–45 1 ☐ Yes 2 🔀 No Specify: Specify 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Horse Trainer Harness Horse Racing 12 permit. Pages 1 and 2 should be filed n Department of Health and Mental Hygic Important: If item 27 Is marked other I any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren Norris Ruth Grim 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Becky Jo Healey / Daughter 96 Driftway, Earleville, MD 21919 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 10/19/2009 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD Double 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician En disease or condition resulting in death) /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician the burial Box 68760 Physician/Medical aftending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. detached 1 Tyes 2 No. 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 🗙 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 Z No 2 No 1 □Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28d. Describe how injury occurred the Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 4 hours after death. Funeral Director: 4 death. 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month.

Day. Year

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